COPY

-Application

University of Tennesee Med. Ctr.

CN1409-042

CERTIFICATE OF NEED APPLICATION

FOR

UNIVERSITY OF TENNESSEE MEDICAL CENTER

Hospital Expansion and Renovation, and the Addition of 44 Acute Care Beds

Knox County, Tennessee

September 15, 2014

Contact Person:

Jerry W. Taylor, Esq.
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401 Commerce Street, Suite 800
Nashville, Tennessee 37219
615-782-2228

Square Footage SECTION A:

APPLICANT PROFILE

1. ***Name of Facility, Agency, or Institution***

University of Tennessee Medical Center
Name

1924 Alcoa Highway — Knox
Street or Route — **County**

Knoxville — TN — 37920
City — **State** — **Zip Code**

2. ***Contact Person Available for Responses to Questions***

Jerry W. Taylor — Attorney
Name — **Title**

Stites & Harbison, PLLC — jerry.taylor@stites.com
Company Name — **Email address**

401 Commerce Street, Suite 800 — Nashville — TN — 37219
Street or Route — **City** — **State** — **Zip Code**

Attorney — 615-782-2228 — 615-742-0302
Association with Owner — **Phone Number** — **Fax Number**

3. ***Owner of the Facility, Agency or Institution***

University Health System, Inc. — 865-305-6600
Name — **Phone Number**

2121 Medical Center Way, Suite 200 — Knox
Street or Route — **County**

Knoxville — TN — 37920
City — **State** — **Zip Code**

4. ***Type of Ownership of Control (Check One)***

A. Sole Proprietorship
B. Partnership
C. Limited Partnership
D. Corporation (For Profit)
E. Corporation (Not-for-Profit) **X**
F. Government (State of TN or
G. Political Subdivision)
H. Joint Venture
I. Limited Liability Company
Other (Specify)_____

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

Legal entity documentation is attached as Attachment A, 4.

5. ***Name of Management/Operating Entity (If Applicable)***

N/A.

Name

Street or Route **County**

City **State** **Zip Code**

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A.	Ownership	D.	Option to Lease
B.	Option to Purchase	E.	Other (Specify) _____
C.	Lease of 50 Years **X**		

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

A copy of the Lease and Transfer Agreement is attached as Attachment A, 6.

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify) General	**X**	I.	Nursing Home
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		J.	Outpatient Diagnostic Center
			K.	Recuperation Center
C.	ASTC, Single Specialty		L.	Rehabilitation Facility
D.	Home Health Agency		M.	Residential Hospice
E.	Hospice		N.	Non-Residential Methadone Facility
F.	Mental Health Hospital		O.	Birthing Center
G.	Mental Health Residential Treatment Facility		P.	Other Outpatient Facility (Specify)_____
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)		Q.	Other (Specify) _____

8. Purpose of Review ***(Check) as appropriate--more than one response may apply)***

A.	New Institution	G.	Change in Bed Complement **X**
B.	Replacement/Existing Facility		*[Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]*
C.	Modification/Existing Facility **X**	H.	Change of Location
D.	Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify)_____	I.	Other (Specify)_____
E.	Discontinuance of OB Services		
F.	Acquisition of Equipment		

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9. **Bed Complement Data**

Please indicate current and proposed distribution and certification of facility beds.

N/A

		Current Beds Licensed	**CON*	*Staffed Beds*	*Beds Proposed*	*TOTAL Beds at Completion*
A.	Medical (Med/surg beds combined on Line B)					
B.	Surgical	422		390*	28	450
C.	Long-Term Care Hospital					
D.	Obstetrical	12		12		12
E.	ICU/CCU	80		80	16	96
F.	Neonatal	67		67		67
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	**581**		**549**	**44**	**625**

*CON-Beds approved but not yet in service

* The 32 unstaffed beds are allocated to occupy the 4th floor of the Heart Hospital, the build out of which was approved by CN0912-056AE. These beds will be opened in November of 2014. All beds for which there is physical space in the hospital are staffed. Upon the opening of the 4th floor of the Heart Hospital, these beds will be staffed as well.

10. **Medicare Provider Number:** 44-0015
Certification Type: Hospital

11. **Medicaid Provider Number:** 0044-0015
Certification Type: Hospital

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid?**

N/A. UTMC is certified for both Medicare and TennCare

13. **Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.**

BlueCare

UnitedHealth Community Plan

TennCare Select

Will this project involve the treatment of TennCare participants?

Yes

If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or plans to contract.

UTMC contracts with all three TennCare MCO listed above. In addition, effective January 1, 2015 UTMC will be under contract with AmeriGroup Community Care.

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

Kentucky Medicaid and Kentucky Medicaid MCOs – Average of 31 inpatients per month.

Cigna – HealthSpring Medicare Advantage – Average of 12 inpatients per month.

NOTE: ***Section B*** **is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project.** ***Section C*** **addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Project Description

The University of Tennessee Medical Center (UTMC) seeks CON authorization for: (1) the expansion and renovation of its Neonatal Intensive Care Unit (NICU) consisting of approximately 9,758 square feet of new construction and 15,432 square feet of renovated space; (2) the addition of approximately 16,850 square feet of new space and renovation of approximately 1,262 square feet of existing space, which will house a new Intensive Care Unit (ICU); (3) the renovation of approximately 12,000 square feet of existing space to convert it from non-inpatient care space to inpatient rooms; and (4) the addition of 44 acute care beds to its license. Of the 44 requested beds, 28 are anticipated to be allocated as general medical surgical beds, and 16 as ICU beds.

Services & Equipment

This project will result in no changes to the services provided by UTMC. It will improve and expand the facility, and provide needed additional bed capacity. There is no major medical equipment involved in this project, but movable medical equipment will be acquired.

Ownership Structure

UTMC is owned by University Health System, Inc. (UHS), a not-for-profit public benefit corporation that was established in 1998 for the purpose of acquiring and operating UTMC. On July 8, 1999, UHS entered into a Lease and Transfer Agreement ("Agreement") between it and the State of Tennessee and the University of Tennessee, which consummated the transfer of UTMC to UHS. Under the Agreement, UHS leases all existing Real Property and Improvements from the State and UT, and is solely responsible for constructing any new buildings or improvements, which it will then own until the expiration of the Agreement in 2049. Accordingly, the project costs for this project are calculated based on actual costs of construction and acquisition rather than on the imputed value of the lease.

Service Area

The primary service area consists of the following 21 counties: Anderson, Blount, Campbell, Claiborne, Cocke, Cumberland, Fentress, Grainger, Hamblen, Hancock, Hawkins, Jefferson, Knox, Loudon, McMinn, Monroe, Morgan, Roane, Scott, Sevier, and Union. Residents of these counties accounted for 25,108, or 92.5%, of the 27,143 total discharges from UTMC in 2013.

Need

UTMC is requesting an additional 44 acute care beds. Of these, 28 will be allocated to general medical surgical use and 16 will be allocated to critical care (ICU) use. These beds are needed to managed extremely high inpatient utilization and occupancy in both categories of beds.

Medical surgical Beds: The University of Tennessee Medical Center, the region's only academic medical center, serves as the regional referral center and sole Level I trauma center for a 21 county service area. The following facts clearly evidence the need for additional medical surgical beds.

In 2013 the adult medical surgical occupancy rate averaged 89.1%, and exceeded 85% every month. There is very little fluctuation in the occupancy – the beds are consistently highly utilized. In 2013 the 11 adult med-surg units at UTMC averaged 95% or greater occupancy 165 days during the year, and 90% or greater occupancy 232 days during the year. In 2013 the adult med-surg units experienced a daily occupancy of 95% or greater occupancy 81 days during the year, and 80% or greater occupancy 325 days during the year.

The current number of medical-surgical beds is not adequate to provide care for all patients who are referred for acute care. The number of referrals not accepted YTD July 2014 is 384. Of those, 229 were critical care patients, leaving 155 patients who needed an general medical surgical bed. If this trend continues there will be over 650 patients in 2014 who need the services of UTMC, but could not be served due to unavailability of beds.

Additionally, Emergency Room visits have increased from 64,500 in 2009 to over 85,000 in 2013. Over 40% of all patients who are treated in the emergency room require use of an acute care bed during the patient's stay. The lack of available beds leads to internal queuing and inefficiencies. In 2014, the average E.D. hold time (the time E.D. patients needing an inpatient bed are required to wait for a bed to become available) has been 235 hours per day. This is drastic increase from 2013, and reflects the serious bed shortage UTMC is facing.

Critical Care Beds: In addition to being the region's only academic medical center and only Level I trauma center for a 21 county service area, it is one of five Joint Commission accredited Comprehensive Stroke Centers in the state and is the only fully trained Adam Williams Initiative hospital in Tennessee. (The Adams Williams Initiative is explained elsewhere in this application). These distinctions mark UTMC as having the infrastructure, staff, equipment and training necessary to provide the highest level of care to the most complex and critically ill patients in the region.

The need for additional critical care beds at UTMC is evidenced in part by the historical utilization and occupancy of the existing critical care beds:

In 2013 the adult critical care units occupancy rate averaged 78.3%, and exceeded 70% every month except for one. There is very little fluctuation in the occupancy – the beds are consistently highly utilized. And it is important to note that critical care beds, because they are distributed among smaller nursing units due to higher patient acuity, cannot be run at the 80% target threshold for all hospital bed types. In 2013 all adult critical care units at UTMC averaged 95% or greater occupancy on 78 days during the year, and 90% or greater occupancy on 115 days during the year. In 2013 the daily occupancy on all adult critical care units at UTMC exceeded 80% 183 days during the year, exceeded 85% on 104 days, exceeded 90% on 41 days, and exceeded 95% on 9 days. These occupancies are clearly unacceptable for critical care beds.

Over the last several years UTMC has been unable to provide care to all the patients in the region who needed the specialized intensive care services offered at UTMC. Each year the hospital is forced to turn away patients referred to it from other hospitals in the region due to a lack of capacity. In 2013, UTMC declined to accept for transfer 144 patients requiring adult intensive care treatment. In 2014, that number increased to 229 patients from January - August. If this continues that number could reach 344 by the end of the year.

Of the patients refused transfer to UTMC, 16.2% of the patients this year were patients suffering a neurological injury/illness, 40.6% suffered from an acute medical illness that exceeded the ability of the transferring hospital, necessitating transfer to a facility with more resources in terms of equipment, training and specialized care providers. Currently the Medicare Case Mix Index for patients treated at UTMC is 1.99. Having such a high CMI value reflects the clinical complexity and resources needed for the patients cared for by UTMC and further demonstrates the ability of UTMC to provide the highest level of care possible to the most critically ill and injured patients.

Due to capacity constraints and a record volume of requests for transfers to UTMC ICUs from the region, the hospital has been on critical (intensive) care hold 114 of the 243 days elapsed January through August in 2014. The result is an increase in the average number of days being on critical (intensive) care unit hold of 9 per month in 2013 to 14 per month in 2014. Thus in 2014 ICU patients were declined for transfer to UTMC's ICU roughly 47% of the time.

By increasing adult intensive care bed capacity UTMC will be better able to serve the needs of the residents and visitors in the region.

Existing Resources

UTMC is the region's only academic medical center, and only Level I Trauma Center. While there are many high quality hospitals in the service area, UTMC is unique among these in that it offers all of the following special services in addition to it being a teaching hospital and Level I Trauma Center: Renal Transplant Center; Regional Perinatal Center (Level II and III NICU); Pediatric Heart Program; Hemophilia Center; Adult Cystic Fibrosis Center; LIFESTAR Aeromedical Program. In that sense, there are no comparable existing resources in the service

area.

According to data received from the Department of Health, the average occupancy rates for hospitals in the service area are 46.7% on licensed beds, and 53.6% on staffed beds.

This does not obviate the need for the requested beds at UTMC. The immediately preceding response, as well as more detailed discussions elsewhere in this application, explains UTMC's need for the beds, regardless of any surplus of beds in the service area as a whole.

Additionally, the unique and specialized services provided by UTMC, as well as patient choice and physician preference, all strongly support the need for additional bed capacity at UTMC, and dictate against a strategy of continuing to turn away would-be admissions with the patients presumably finding a bed at another area hospital.

Project Cost & Funding

The total estimated project cost is $26,292,001. The largest single item is the construction cost of $16,031,504, and a related contingency of $2,404,726. The reasonableness of this cost is verified by the project architect in Attachment C, II, Economic Feasibility, 1.

The next largest cost is movable equipment at a cost of $4,359,965. No major medical equipment is involved. The only single piece of equipment over $50,000 is an Omnicell, which is a state of the art medication dispensing unit, and will be tied into patients' Electronic Health Records. One of these will be purchased for each of the units. All equipment purchase amounts were negotiated at arms-length among experienced healthcare purchasers and vendors and are reasonable.

The project will be funded through the cash reserves of the owner, University Health System, Inc.

Financial Feasibility

The project is financially feasible. The Financial Statements of UHS reflect sufficient cash reserves to fund the project. As reflected on the Projected Data Chart, both the med/surg and the ICU bed additions will have a positive net operating income in each of the first two years of operation. The margins decrease in the second year, resulting from assumed declining reimbursement rates from government payors. In any event, the Financial Statements reflect sufficient assets to ensure financial viability.

Staffing

UTMC proposes to staff the additional beds with the same general staffing pattern as it currently utilizes on comparable units of comparable size. For the 28 bed med/surg unit, that will require a total of 41.13 clinical positons. For the 16 bed critical care unit, it will require 49.01 clinical positions.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. **Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.**

If the project involves none of the above, describe the development of the proposal.

There are three components of this project which involve construction and/or renovation of the physical plant:

1. Expansion of the Neonatal Intensive Care Unit (NICU). The NICU is located on the 3rd floor of the North Pavilion. It has 67 beds/basinets. The NICU currently consists of 26,851 square feet of space. Of this, 15,432 square feet, which is an "open floor" unit (no dividing walls between bassinets) with 33 beds, will be renovated into separately walled, single occupancy rooms. This is the second phase of renovation to the NICU. The first phase was completed in February, 2007 and consisted of essentially the same changes – converting a multi-basinet, open floor unit to separately walled, mostly single rooms.

The NICU will also be expanded by adding a new construction addition adjoining the current unit on the north side. This will be accomplished by building new space on what is now the roof of the 2nd floor. The new construction will consist of 9,758 square feet. No additional NICU beds are being requested. The additional space is needed in order for the entire NICU to comply with new codes requirements, and to provide infants and families with adequate and comfortable space.

2. A new Intensive Care Unit (ICU) will be located on the 4th floor of the North Pavilion. This new construction addition will adjoin the current building, and will be on top of the new space constructed for the NICU on the 3rd floor. It will consist of 16,850 square feet of new space. In addition, minor renovation will be required to the elevator lobby (mainly for purpose of adjoining the existing building to the newly constructed addition) which renovation will consist of 1,262 square feet. This addition will house the 16 requested additional beds for the ICU.

3. Renovation of the 6th floor of the South Tower. This space consists of 12,000 square feet and is currently not used for inpatient care; it houses outpatient physician clinical offices. This space will be renovated and converted to general acute care bed space. The offices currently occupying the space will be relocated to a medical office building on the UTMC campus. This space will house 28 of the additional beds requested. All rooms will

be single occupancy.

A completed Square Footage and Cost per Square Foot Chart is attached on the following page.

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

UTMC is requesting a total of 44 additional acute care beds. The 44 beds will be allocated as follows:

- 28 beds for general acute medical/surgical patients, to be located in the renovated space on the 6th floor of the South Pavilion.
- 16 beds for ICU patients, to be located in the newly constructed ICU on the 4th floor of the North Pavilion.

These bed additions are needed in order to address the overwhelming demand for beds UTMC has and is experiencing. The need for the beds is addressed in detail in Section C, I, Need of this application. The bed addition will not impact other services of the hospital, but will allow UTMC to better meet the needs of its patients and provide more effective and efficient inpatient services.

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
NICU	3rd Floor	26,851	NA	3rd Floor	15,432	9,758	25,190	$200	$336.43	$6,369,256
New ICU	NA	NA	NA	4th Floor	1,262	16,850	18,112	$200.10	$345.74	$6,078,248
6 South	NA	NA	NA	6 South	12,000	.	12,000	$298.67		$3,584,000
B. Unit/Depart. GSF Sub-Total										
C. Mechanical/ Electrical GSF	Included above									
D. Circulation /Structure GSF	Included above Included above									
E. Total GSF										$16,031,504

C. **As the applicant, describe your need to provide the following health care services (if applicable to this application):**

N/A. This application does not involve the initiation of any health care service.

1. **Adult Psychiatric Services**
2. **Alcohol and Drug Treatment for Adolescents (exceeding 28 days)**
3. **Birthing Center**
4. **Burn Units**
5. **Cardiac Catheterization Services**
6. **Child and Adolescent Psychiatric Services**
7. **Extracorporeal Lithotripsy**
8. **Home Health Services**
9. **Hospice Services**
10. **Residential Hospice**
11. **ICF/MR Services**
12. **Long-term Care Services**
13. **Magnetic Resonance Imaging (MRI)**
14. **Mental Health Residential Treatment**
15. **Neonatal Intensive Care Unit**
16. **Non-Residential Methadone Treatment Centers**
17. **Open Heart Surgery**
18. **Positron Emission Tomography**
19. **Radiation Therapy/Linear Accelerator**
20. **Rehabilitation Services**
21. **Swing Beds**

D. **Describe the need to change location or replace an existing facility.**

N/A. This application does not involve the relocation or replacement of a healthcare facility.

E. **Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $2 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:**

N/A. This application does not involve any major medical equipment.

1. **For fixed-site major medical equipment (not replacing existing equipment):**
   a. **Describe the new equipment, including:**
      1. **Total cost ;(As defined by Agency Rule).**

2. **Expected useful life;**

3. **List of clinical applications to be provided; and**

4. **Documentation of FDA approval.**

b. **Provide current and proposed schedules of operations.**

2. **For mobile major medical equipment:**

a. **List all sites that will be served;**

b. **Provide current and/or proposed schedule of operations;**

c. **Provide the lease or contract cost.**

d. **Provide the fair market value of the equipment; and**

e. **List the owner for the equipment.**

3. **Indicate applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.**

III. (A) **Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which must include:**

1. **Size of site (*in acres*);**
2. **Location of structure on the site; and**
3. **Location of the proposed construction.**
4. **Names of streets, roads or highway that cross or border the site.**

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

A plot plan for the UTMC Campus is attached as Attachment B, III, (A).

(B)

1. **Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.**

   UTMC is located on Alcoa Highway, a major public highway. It is located approximately 3 miles from Interstates 40 and 75. It is on a public transportation (bus) route, although most patients come to the hospital by private car or by ambulance.

IV. **Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.**

NOTE: *DO NOT SUBMIT BLUEPRINTS*. Simple line drawings should be submitted and need not be drawn to scale.

Floors plan drawings for all areas of the hospital affected by construction, renovation and/or bed additions are attached as collective Attachment B, IV.

V. **For a Home Health Agency or Hospice, identify:**

N/A.

1. **Existing service area by County;**
2. **Proposed service area by County;**
3. **A parent or primary service provider;**
4. **Existing branches; and**
5. **Proposed branches.**

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper*. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

I. NEED

1. **Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.**

   a. **Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.**

   The State Health Plan includes the following aspirational goals for health care delivery in Tennessee:

   Five Principles for Achieving Better Health from the Tennessee State Health Plan:

   1. Healthy Lives

   The purpose of the State Health Plan is to improve the health of Tennesseans.

   Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and our genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.

This is a policy statement to which no response is necessary.

2. Access to Care

Every citizen should have reasonable access to health care. Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.

UTMC is accessible to all patients regardless of socio-economic status, ethnicity or payor source. UTMC participates in Medicare and TennCare, and contracts with all TennCare MCOs operating in the region.

3. Economic Efficiencies

The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.

UTMC is an excellent steward of the state's health care resources. As the only academic medical center in the region, UTMC provides a training site, educational resources, and of course patients for the training of future physicians and other health care practitioners. It is the only Level I Trauma Center in its 21 county primary service area. Its services include a Level III NICU, providing lifesaving care for critically ill newborns. And UTMC maintains its facilities, equipment and services so as to remain innovative, efficient, and competitive in a robust health care market place.

4. Quality of Care

Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.

UTMC will continue to provide the highest quality of care to its patients. It is in good standing with the Tennessee Board for Licensing Health Care Facilities, and is accredited by and in good standing with the Joint Commission. UTMC has received numerous awards and recognitions of the high quality of care it provides. UTMC received Magnet designation in 2011. Magnet designation recognizes excellence in patient care, nursing outcomes and innovation in professional nursing practice. In addition to the Magnet designation, UTMC was awarded a Level III achievement

from the Tennessee Center for Performance Excellence in 2012. A list of recent recognitions is attached as Attachment C, I, Need, I.

5. Health Care Workforce

The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.

UTMC is a major employer in the greater Knoxville area, employing over 4,000 individuals. Its employed health care staff -- which includes but is not limited to physicians, mid-level providers, and nurses – represents strong clinical specialties among a diverse workforce. UTMC is staffed at a level which complies with all licensure and accreditation guidelines, and which assures high quality patient care while maintaining efficiencies. UTMC is also the only academic medical center in the region, providing a training site and educational resources for future physicians and a large number of other clinical specialties. Please see the discussion in response to Question C, III, Orderly Development 6 and the attachment thereto.

[End of responses to Five Principles for Achieving Better Health]

The State Health Plan has not yet updated the Acute Care Bed Need Services guidelines, so the following from the Guidelines for Growth are still in effect.

ACUTE CARE BED NEED SERVICES

1. **The following methodology should be used and the need for hospital beds should be projected four years into the future from the current year.**

   Using the latest utilization and patient origin data from the Joint Annual Report of Hospitals and the most current population projection series from the Department of Health, perform the following:

The applicant incorporates the calculation of bed need as performed by the Department of Health. Therefore, the recitation of the bed need formula from the Guidelines is not repeated here.

A table showing the bed need calculations for the service area, extracted from the state-wide calculations from the Department of Health are attached as Attachment C,

I, Need, 1, (1). Behind that document is the complete state-wide calculations from the Department of Health.

According to those documents, there is a calculated bed surplus in the service area of 1,250 beds based on licensed beds, and a surplus of 593 beds based on 2012 staffed beds as reflected in the 2012 JARs. For Knox County, the calculated surplus is 263 based on licensed beds, and 163 based on staffed beds.

The calculated bed surplus does not obviate UTMC's need for the requested 44 beds for the reasons explained below.

UTMC's Need for Medical Surgical Beds:

The University of Tennessee Medical Center, the region's only academic medical center, serves as the regional referral center and sole Level I trauma center for a 21 county service area. The current number of medical-surgical beds is not adequate to provide care for all patients who are referred for acute care. The following facts clearly evidence the need for additional medical surgical beds.

As reflected on Attachment C, I, Need, 1, Chart 1 in 2013 the adult medical surgical occupancy rate averaged 89.1%, and exceeded 85% every month. There is very little fluctuation in the occupancy – the beds are consistently highly utilized.

As reflected on Attachment C, I, Need, 1, Chart 2 in 2013 the 11 adult med-surg units at UTMC averaged 95% or greater occupancy 165 days during the year, and 90% or greater occupancy 232 days during the year.

As reflected on Attachment C, I, Need, 1, Chart 3 in 2013 the adult med-surg units experienced a daily occupancy of 95% or greater occupancy 81 days during the year, and 80% or greater occupancy 325 days during the year.

Below are several additional contributing factors that necessitate additional medical-surgical, acute care beds to accommodate the current needs of the region:

- The number of referrals not accepted YTD July 2014 is 384. Of those, 229 were critical care patients, leaving 155 patients who needed an general medical surgical bed. If this trend continues there will be over 650 patients in 2014 who need the services of UTMC, but could not be served due to unavailability of beds.
- Emergency Room visits have increased from 64,500 in 2009 to over 85,000 in 2013. Over 40% of all patients who are treated in the emergency room require use of an acute care bed during the patient's stay. The lack of available beds leads to internal queuing and inefficiencies. In 2014, the average E.D. hold time (the time

E.D. patients needing an inpatient bed are required to wait for a bed to become available) has been 235 hours per day. This is drastic increase from 2013, and reflects the serious bed shortage UTMC is facing.

UTMC Emergency Department
Historic and Projected Visits By Level of Acuity

ED Visits by Acuity Level	CY2013	CY 2014 (Annualized)	Projected Visits CY2015	Projected Visits CY2016	E.D. Holds (Hours)
Level I	865	950	959	969	
Level II	15,734	17,715	17,882	18,061	
Level III	41,166	39,812	40,188	40,590	
Level IV	20,698	20,367	20,559	20,765	
Level V	1,982	2,277	2,299	2,322	
Trauma	4,288	4,176	4,215	4,258	
Totals	84,733	85,296	86,102	86,964	
Treatment Stations	48	57	57	57	
Visits Per Station	1,765	1,496	1,511	1,526	
					2013: 92 average hold hours a day
Source: Internal hospital records					2014: 235 average hold hours a day

UTMC's Need for Critical Care Beds

In addition to being the region's only academic medical center and only Level I trauma center for a 21 county service area, it is one of five Joint Commission accredited Comprehensive Stroke Centers[1] in the state and is the only fully trained Adam Williams Initiative hospital[2] in Tennessee. These distinctions mark UTMC as having the infrastructure, staff, equipment and training necessary to provide the highest level of care to the most complex and critically ill patients in our region.

Over the last several years UTMC has been unable to provide care to all the patients in the region who needed the specialized intensive care services offered at UTMC. Each year the hospital is forced to turn away patients referred to it from other hospitals in the region due to a lack of capacity. In 2013, UTMC declined to accept for transfer 144 patients requiring adult intensive care treatment. In 2014, that

[1] The Joint Commission and American Heart Association/American Stroke Association Comprehensive Stroke Center designation is an advanced certification recognizing hospitals with the specific abilities to receive and treat the most complex stroke cases leading to better patient outcomes.

[2] The Adam Williams Initiative is a philanthropic foundation endorsed by the Brain Trauma foundation, the American Association of Neurological Surgeons and the National Foundation for Trauma Care. The foundation provides free training and capital equipment to military and civilian trauma centers for the treatment of severe traumatic brain injuries. The Initiative's goal is to help establish a higher standard of care for traumatic brain injury patients.

number increased to 229 patients from January - August. If this continues that number could reach 344 by the end of the year.

Of the patients refused transfer to UTMC, 16.2% of the patients this year were patients suffering a neurological injury/illness, 40.6% suffered from an acute medical illness that exceeded the ability of the hospital currently providing care, necessitating transfer to a facility with more resources in terms of equipment, training and specialized care providers. Currently the Medicare Case Mix Index for patients treated at UTMC is 1.99. Having such a high CMI value reflects the clinical complexity and resources needed for the patients cared for by UTMC and further demonstrates the ability of UTMC to provide the highest level of care possible to the most critically ill and injured patients.

Due to capacity constraints and a record volume of requests for transfers to UTMC ICUs from the region, the hospital has been on critical (intensive) care hold 114 of the 243 days elapsed January through August in 2014. The result is an increase in the average number of days being on critical (intensive) care unit hold of 9 per month in 2013 to 14 per month in 2014. Thus in 2014 ICU patients were declined for transfer to UTMC's ICU roughly 47% of the time.

Requests for ICU patient transfers tend to come in clusters particularly when UTMC is on critical (intensive) care hold. As many as 8 patients in one 24 hour period have been refused for transfer to UTMC due to all intensive care units being full to capacity. UTMC aims to maintain a goal occupancy rate of 70% - 80% to maintain maximal efficiency and effectiveness.

August year-to-date 2014, there are multiple examples of between 10–14 patients requiring intensive care being unable to transfer to UTMC's ICU within a 3 consecutive day period. With an average ICU ALOS of 3.59 days, a 16 bed ICU would have an occupancy rate from 63% to 88%, while all other current ICUs would be running at 100% occupancy (on days the hospital is on critical (intensive) care unit hold).

The need for additional critical care beds at UTMC is clearly evidenced by the historical utilization and occupancy of the existing critical care beds:

As reflected on Attachment C, I, Need, 1, Chart 4 the adult critical care units occupancy rate averaged 78.3%, and exceeded 70% every month except for one. There is very little fluctuation in the occupancy – the beds are consistently highly utilized. And it is important to note that critical care beds, because they are distributed among smaller nursing units due to higher patient acuity, cannot be run at the 80% target threshold for all hospital bed types.

As reflected on Attachment C, I, Need, 1, Chart 5 in 2013 all adult critical care units at UTMC averaged 95% or greater occupancy on 78 days during the year, and 90% or greater occupancy on 115 days during the year.

As reflected on Attachment C, I, Need, 1, Chart 6 in 2013 the daily occupancy on all adult critical care units at UTMC exceeded 80% 183 days during the year, exceeded 85% on 104 days, exceeded 90% on 41 days, ,and exceeded 95% on 9 days.

These occupancies are clearly unacceptable for critical care beds. By increasing adult intensive care bed capacity UTMC will be better able to serve the needs of the residents and visitors in the region.

UTMC's Need for Teaching Beds

Another factor contributing to the need for addition beds relates to UTMC's position as the only academic medical center in the region. UTMC has a total of 210 Residents and Fellows (physicians in advanced training seeing patients every day and fulfilling our commitment as a teaching hospital and training the next generation of physicians). 18 of this number are in Dentistry (10 are in Oral-Maxillofacial Surgery and are essential to the trauma programs). 27 of these Residents/Fellows are supported through funding directly from UTMC.

In order to maintain accreditation for these training programs certain patient volumes and encounters are required. As medical schools are encouraged to increase enrollments to meet the projected physician shortages, additional resident/fellow positions will be required at teaching hospitals/academic medical centers. This will also contribute to the need for additional beds in the future.

The need for additional teaching beds, whether they be medical surgical or critical care, cannot be quantified, but this is nonetheless an important contributing factor to be taken into account.

Verification of Bed Need Projections -- Poisson Probability Bed Need

UTMC is requesting a total of 44 addition acute care beds. Of these, 28 will be allocated to general medical surgical use and 16 will be allocated to critical care use. In order to verify the need for additional beds, and the number of requested beds, UTMC applied the Poisson Probability Bed Need methodology. The results are reflected in Attachment C, I, Need, 1, Chart 7.

The Poisson Probability Bed Need methodology is a statistically valid methodology, generally accepted by health planning professionals. It calculates the number of beds needed by an inpatient facility in order for that facility to have a given level of likelihood of having a bed available when needed. For example, the 90% probability target means that if the facility has the calculated number of beds, there is a 90% likelihood one will be available when needed.

This projection methodology is the same approach used in the Acute Care Bed Need Services formula found in *Guidelines for Growth, 2000 Edition.* For purposes of this projection, we considered only adult ICU beds and adult medical surgical beds. Rather than applying the formula to the entire service area, UTMC instead applied it to UTMC based on historical utilization.

1. "The need for hospital beds should be projected four years into the future from the current year." UTMC's projection year is 2018.

2. "Determine the current Average Daily Census (ADC) in each county." The service area is comprised of UTMC's traditional 21 service area counties. In determining its own bed need, UTMC calculated its own ADC, rather than that for the service area as a whole. The 2013 average daily census (ADC) is based upon actual hospital-wide experience at UTMC for the adult medical/surgical beds and the adult ICU beds.[3]

3. "Determine the service area population (SAP) in both the current and projected year." Population estimates and projections were obtained from the Tennessee Office of Health Statistics, revised 6/2013. The UTMC 21-county SAP growth rate is 4.8% for the period from 2013 to 2018.

4. "Determine the projected Average Daily Census as: Projected ADC = Current ADC x (Projected SAP ÷ Current SAP)." Current 2013 UTMC ADC was multiplied by (1 + 4.8%) to yield projected 2018 UTMC ADC.

5. "Calculate Projected Bed Need for each county as: Projected Need = Projected ADC + 2.33 x $\sqrt{}$(Projected ADC)." According to a normal probability distribution function, 2.33 is the Z Score that corresponds with 99% probability of having a bed available when a bed is needed. For sensitivity purposes, and to be conservative with bed need projections, UTMC also provides the 90% probability (Z = 1.28) and the 95% probability (Z = 1.645).

6. Determine the 2018 Projected Net Bed Need as: 2018 Net Bed Need or (Surplus) = 2018 Projected Need - 2013 Licensed Beds. Since it is impossible to have a fraction of a bed available, Projected Need is always rounded up to the next whole integer (e.g., 15.1 ≠ 15, 15.1 = 16; 15.9 = 16).

The results of applying the formula to UTMC reflect the following:

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[3] UTMC does not maintain a separate unit for observation patients, or even outpatient bedded patients. Observation patients are cared for on the nursing units in the unit most closely associated with the patient's diagnosis. Though observation patients are a rarity in the ICU units, some are distributed among the medical/surgical units. Like many hospitals without distinct observation units, UTMC's bed need must consider the mix of traditional inpatients with observation patients, etc. These distinctions are becoming even more blurred with federal implementation of the 2-Midnight Rule. However these various patients are categorized for reimbursement purposes, there is no distinction operationally and all require a bed.

Conclusion: UTMC's request for 16 additional adult ICU beds and 28 additional adult medical/surgical beds is consistent with Projected Bed Need at the 90% probability (17 beds and 57 beds, respectively), the 95% probability (25 beds and 79 beds, respectively) as well as the 99% probability (39 beds and 118 beds, respectively). Rather than seeking the full 157 additional beds (39 + 118 = 157) according to the 99% probability using the official acute care bed need methodology, UTMC is seeking far fewer beds – only 44 additional beds (16 + 28 = 44).

Approval of UTMC's request for 16 additional adult ICU beds and 28 additional adult medical/surgical beds will result in 91 total adult ICU beds (75 + 16 = 91) and 402 total adult medical/surgical beds (337 +5 previously out of service + 32 to be put in service in the Heart Hospital in November +28 = 402). With a projected ADC of 62.1 and 298.6, respectively, UTMC's 2018 projected occupancy, based on this methodology, is nearly 70% for adult ICU (62.1 ÷ 91 = 68.2%) and nearly 75% for adult medical surgical (300.8 ÷ 402 = 74.3%).[4]

Conclusion: The official Acute Care Bed Need Services methodology found in *Guidelines for Growth, 2000 Edition* projects a surplus of beds in Knox County, UTMC's 21-county service area and throughout the entire state. The same methodology, applied to UTMC itself, projects a need for additional adult ICU beds and adult medical/surgical beds. That a single methodology produces such disparate results testifies to the high utilization at UTMC and requires further evaluation. Therefore, UTMC also presents bed need projections based upon additional factors that are specific to its tertiary regional referral hospital role.

2. New Hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

a) All existing hospitals in the projected service area have an occupancy level greater than or equal to 80 percent for the most recent Joint Annual Report. Occupancy should be based on the number of licensed beds that are staffed for two consecutive years.

According to data received from the Department of Health, this occupancy threshold is not met. The average occupancy rates for hospitals in the service area are 46.7% on licensed beds, and 53.6% on staffed beds.

This does not obviate the need for the requested beds at UTMC. The immediately preceding response explains UTMC's need for the beds, regardless of any surplus of

[4] The projected utilization charts shown in response to Question C, I, Need, 6 reflect different occupancy rates, because those are based on the applicant's actual historical growth in patient days, whereas the Poisson methodology is based on the service area population growth rate only. Accordingly, this is a much more conservative methodology and results in lower projected occupancy.

beds in the service area as a whole. This need is verified by applying the bed need formula to UTMC's historical utilization.

Additionally, the unique and specialized services provided by UTMC, as well as patient choice and physician preference, all strongly support the need for additional bed capacity at UTMC, and dictate against a strategy of continuing to turn away would-be admissions with the patients presumably finding a bed at another area hospital.

UTMC is a tertiary, regional referral hospital with significant admissions coming from throughout the 21 county primary service area and beyond. "A bed is a bed" is not a truism that applies to UTMC. While there are many high quality hospitals in the service area, UTMC is unique among these in that it offers all of the following special services:

- Area's only Academic Medical Center
- Area's only Level I Trauma Center
- Renal Transplant Center
- Regional Perinatal Center (Level II and III NICU)
- Pediatric Heart Program
- Hemophilia Center
- Adult Cystic Fibrosis Center
- LIFESTAR Aeromedical Program

The number of declined admissions at UTMC due to the unavailability of beds is significant and growing. (See discussion in response to the immediately preceding question). The additional capacity at UTMC will remedy this, at least for the time being, and allow the hospital to admit and treat patients for whom they, their families and/or physicians have determined that UTMC is the provider of choice.

b) All outstanding CON projects for new acute care beds in the proposed service area are licensed.

There are no unimplemented CONs for additional acute care beds in the service area.

c) The Health Facilities Commission may give special consideration to acute care bed proposals for specialty health service units in tertiary care regional referral hospitals.

UTMC is a tertiary care regional referral hospital. Significant numbers of referrals and admissions are received from the defined 21 county service area. UTMC is the only Level I Trauma Center in the service area, resulting in a high volume of E.D. visits and admissions. UTMC is also the only academic medical center in the region, providing a training site and educational resources for future physicians and other health care practitioners.

[End of responses to Acute Care Bed Need Services from the Guidelines for Growth]

The Guidelines for Growth also includes standards and criteria for hospital expansion and renovation projects. Responses to these are reflected below.

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE FACILITIES.

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

Responses to the Acute Care Bed Need Services guidelines are included in the immediately preceding section.

2. For relocation or replacement of existing licensed health care institution:

a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

N/A. This application does not include a replacement facility or relocation.

3. For renovation or expansions of an existing licensed health care institution:

a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

NICU Expansion: Of the 67 licensed NICU beds, 33 of those are currently housed on an open floor which has no dividing walls between the beds. There is also no external natural lighting available on this unit. While the highest level of care is obviously still provided on this unit, the private rooms, larger per bed space, and external lighting are all significant improvements in comfort and privacy for the infants and their families. There is no space available within the walls to provide these improvements, so the proposed addition is necessary.

This is the second phase of renovation to the NICU. The first phase was completed in February, 2007 and consisted of essentially the same changes – converting a multi-

basinet, open floor unit to separately walled, mostly single rooms. This proposed second phase will complete the renovation and modernization of the 67 bed NICU. No beds are being added to the NICU.

ICU Expansion/Addition: UTMC currently has 80 ICU/CCU beds. Occupancy on the ICU beds runs extremely high, and additional capacity is needed. UTMC intends to allocate 16 of the requested 44 additional acute care beds to ICU use. The need for these beds is addressed elsewhere in this application. There is no physical space within the walls to house the beds, so the addition is necessary. The proposed addition of the NICU will extend out over what is now the roof of the 2nd floor, and the proposed ICU addition will be constructed on top of the NICU addition.

Renovation/Conversion of 6th Floor South to Inpatient Rooms: UTMC proposes to allocate 28 of the requested 44 additional acute care beds to general medical/surgical use. The need for these beds is addressed elsewhere in this application. These 28 new med/surg beds will be located on the 6th floor of the East Pavilion. This space is currently being used for non-inpatient care purposes. These existing uses will be relocated to existing space in a medical office building on the campus. The space will be renovated into 28 private inpatient rooms. This is a more cost effective approach than new construction, although specific cost estimates for new construction of roughly 12,000 square feet of new construction were not obtained.

b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

The renovations being made to the existing space is not based on the condition of the physical plant. As explained above, the renovations are being made to accommodate and tie into the new space, and/or to convert the use of the space.

[End of responses to Renovation/Expansion Guidelines]

b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)

N/A.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

Long range planning and development is an on-going process at UTMC, in order to keep pace with patients' needs and demands for services. Over the last approximately 10 years, UTMC has received CON approvals for the following projects:

- Addition of a PET/CT (CN0310-089A)
- Addition of a Cyber Knife (CN0402-007A)

- Addition of a second Linear Accelerator (CN0803-019A)
- Construction of a 4 floor addition for cardiac services now known as the Heart Hospital (CN0801-004A)
- Build out of the 3rd and 4th floors of the Heart Hospital (originally shelled space) (CN0912-056A)
- Addition of a 3.0 Tesla MRI (CN1002-008A)
- A 28,000 square foot expansion of the surgical facilities and a net increase of 10 ORs (CN1005-022A)

As previously mentioned, UTMC also accomplished the Phase I modernization of the NICU in February, 2007 which did not require CON approval.

All of these improvements and expansions have been accomplished without any addition of acute care beds. Now the demand for inpatient beds and the extremely high utilization of existing beds, discussed above and elsewhere in the application, necessitates additional beds. UTMC has taken interim measures to free up bed space, and while those steps have provided some limited temporary relief, only the additional licensed beds can provide the additional inpatient capacity needed. The interim measures taken by UTMC to maximize bed capacity are described in response to question C, II, Economic Feasibility 11.

3. **Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on 8 1/2" x 11"**

The primary service area consists of the following 21 counties: Anderson, Blount, Campbell, Claiborne, Cocke, Cumberland, Fentress, Grainger, Hamblen, Hancock, Hawkins, Jefferson, Knox, Loudon, McMinn, Monroe, Morgan, Roane, Scott, Sevier, and Union. Residents of these counties accounted for 25,108, or 92.5%, of the 27,143 total discharges from UTMC in 2013.

A map of the service area is attached as Attachment C, I, Need, 3.

4. **A. Describe the demographics of the population to be served by this proposal.**

A table reflecting the population and relevant demographics of the service area is attached as Attachment C, I, Need, 4.

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans

of the facility will take into consideration the special needs of the service area population.

As reflected in the Population and Demographics table attached as Attachment C, I, Need, 4, there are several relevant demographic characteristics of the service area population which support the need for additional inpatient capacity at UTMC.

Every county in the service area has a larger percentage of residents age 65+ to the total population than does the state as a whole.

14 of the 21 counties in the service area have a larger proportion of TennCare enrollees than does the state as a whole.

13 of the 21 counties in the service area have a larger proportion of its population living below poverty level than does the state as a whole.

So in general, the service area population is older and poorer than the population of the state as a whole. The elderly population tend to be heavier users of medical services, including inpatient hospital services, than does the younger population. So having beds available at UTMC to meet this population's health needs is important. UTMC's services are available to all regardless of financial status or payor source. UTMC is in network with all TennCare MCOs in the region. So the economically disadvantaged would benefit from this proposal as well.

5. **Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.**

Data from the Department of Health reflecting beds, patient days and occupancy for each hospital in the 21 county service area is attached as Attachment C, I, Need, 5 (1). This is the most recent compiled data the Department of Health has available. Although it does not reflect 3 years of data, this should be considered sufficient since: (1) occupancy rates are clearly below the 80% threshold, and the applicant does not dispute that; and (2) the need for the beds at UTMC is not obviated by the fact there are open beds elsewhere in the service area. Please see the discussion in response to standard 2 of the Acute Care Bed Needs, earlier in this application.

A list of the outstanding CONs held by hospitals in the service area is attached as Attachment C, I, Need, 5 (2). There are no unimplemented CONs for additional acute care beds in the service area. These projects will not impact, or be impacted by, this project.

6. **Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.**

The historic utilization of adult medical surgical and adult critical care beds at UTMC and the projected utilization of the requested beds are reflected in the tables below.

UTILIZATION OF MEDICAL – SURGICAL BEDS UTMC 2012 through PROJECT YEAR 2						
Year	Med-surg Beds	Inpatient Days	Average Occupancy without Obsv. Days	Observation Days	Total Patient Days	Total Average Occupancy with Obsv. Days
Historic						
CY2012	327	82,852	69.4%	15,888	98,740	82.7%
CY2013*	319	87,822	75.4%	16,154	103,976	89.3%
CY2014**	342	91,208	73.1%	25,013	116,220	93.1%
Projected						
Year 1	402	106,303	72.4%	21,261	127,564	86.9%
Year 2	402	107,366	73.2%	21,473	128,840	87.8%

**Excluded 4E because unit had to be temoporarily closed frm Jan.-Sept.*

***Annualized on 8 months data*

Source: Internal hospital records

PROJECTED UTILIZATION OF ADDITIONAL MED-SURG BEDS UTMC FLOOR 6 SOUTH -- through PROJECT YEAR 2						
Year	No. of Beds	Inpatient Days	Average Occupancy without Obsv. Days	Observation Days	Total Patient Days	Total Average Occupancy with Obsv. Days
Historic						
CY2012						
CY2013						
CY2014*						
Projected						
Year 1	28	7,358	72.0%	1,840	9,198	90.0%
Year 2	28	7,506	73.4%	1,876	9,382	91.8%

UTILIZATION OF CRITICAL CARE BEDS (Excludes Pediatric ICU) ICU) UTMC 2012 through PROJECT YEAR 2				
Year	**Critical Care Beds**	**Inpatient Days**	**Average Occupancy without Obsv. Days****	**Observation Days**
Historic				
CY2012	75	21,687	79.2%	n/a
CY2013	75	21,563	78.8%	n/a
CY2014*	75	22,346	81.6%	n/a
Projected				
Year 1	91	27,241	82.0%	n/a
Year 2	91	27,606	83.1%	n/a

UTILIZATION OF ADDITIONAL BEDS UTMC NEW ICU Through PROJECT YEAR 2				
Year	**No. of Beds**	**Inpatient Days**	**Average Occupancy without Obsv. Days***	**Observation Days**
Historic				
CY2012				
CY2013				
CY2014*				
Projected				
Year 1	16	4672	80.0%	n/a
Year 2	16	4765	81.6%	n/a

** There very few observation days on the critical care units.*

These projections were derived by extrapolating historic growth rates for both inpatient and observation days at UTMC. It was assumed the inpatient growth rates would remain constant throughout the projection period. Downward adjustments were made to the observation days, because it is believed the most recent accelerated growth in observation days is spawned in part by recent CMS policy changes, e.g., the "two midnight rule." Also taken into consideration was the number of referrals and transfers to UTMC that had to be refused due to a lack of beds. Different time bases were applied to the different units, because the med-surg unit is projected to open before the critical care unit.

II. ECONOMIC FEASIBILITY

1. **Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.**

    - **All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)**
    - **The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.**
    - **The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.**

For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.

A completed Project Cost Chart is attached following this response.

Justification of the reasonableness of the estimated cost is provided in response to question C, II, Economic Feasibility, 3 below.

A letter from the project architect is attached as Attachment C, II, Economic Feasibility, 1.

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:	
	1. Architectural and Engineering Fees	$ 801,576.00
	2. Legal, Administrative, Consultant Fees	$ 45,000.00
	3. Acquisition of Site	NA
	4. Preparation of Site	NA
	5. Construction Costs	$ 16,031,504.00
	6. Contingency Fund	$ 2,404,726.00
	7. Fixed Equipment (Not included in Construction Contract)	$ 2,604,230.00
	8. Moveable Equipment (List all equipment over $50,000.00) Omnicell $70,000	$ 4,359,965.00
	9. Other (Specify) _____	
B.	Acquisition by gift donation, or lease:	
	1. Facility (Inclusive of building and land)	$ -
	2. Building Only	$ -
	3. Land Only	$ -
	4. Equipment (Specify) _____	$ -
	5. Other (Specify) _____	$ -
C.	Financing Costs and Fees:	
	1. Interim Financing	$ -
	2. Underwriting Costs	$ -
	3. Reserve for One Year's Debt Service	$ -
	4. Other (Specify) _____	$ -
D.	Estimated Project Cost (A+B+C)	$ 26,247,001.00
E.	CON Filing Fee	$ 45,000.00
F.	Total Estimated Project Cost (D & E)	$ 26,292,001.00
	TOTAL	$ 26,292,001.00

2. **Identify the funding sources for this project.**

   a. **Please check the applicable item(s) below and briefly summarize how the project will be financed.** ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

__ **A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;**

__ **B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;**

__ **C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.**

__ **D. Grants--Notification of intent form for grant application or notice of grant award; or**

X **E. Cash Reserves--Appropriate documentation from Chief Financial Officer.**

A letter from the Chief Financial Officer for UTMC is attached as Attachment C, II, Economic Feasibility, 2.

__ **F. Other—Identify and document funding from all other sources.**

3. **Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.**

The total estimated project cost is $26,292,001. The largest single item is the construction cost of $16,031,504, and a related contingency of $2,404,726. The reasonableness of this cost is verified by the project architect in Attachment C, II, Economic Feasibility, 1.

As reflected on the Square Footage and Cost Per Square Footage Chart, the cost for renovation range from $200 per square foot to $299 per square foot. The new construction costs range from $336 per square foot to $346 per square foot.

The renovation cost p.s.f. is slightly above the 3rd Quartile of approved CON hospital costs for applications approved 2011-2012, which is $249 p.s.f. The new

construction cost is likewise slightly above the 3rd Quartile of approved CON hospital costs for applications approved 2011-2012, which is $324 p.s.f. Part of the reason the UTMC estimated cost is higher is due to inflation, and part of it is due to the fact this construction job has challenges as far as extending out over a current roof area. This is generally more expensive that building on open ground.

The next largest cost is movable equipment at a cost of $4,359,965. No major medical equipment is involved. The only single piece of equipment is an Omnicell, which is a medication dispensing unit, which is state of the art and will be tied into patients' Electronic Health Records. All equipment purchases were negotiated at arms-length among experienced healthcare purchasers and vendors and are reasonable.

The Architectural and Engineering fees were likewise negotiated at arms-length and the professionals providing these services are experienced and well known to the management team at UTMC. These fees are reasonable.

4. **Complete Historical and Projected Data Charts on the following two pages--*Do not modify the Charts provided or submit Chart substitutions!* Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the *Proposal Only* (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).**

   Attached on the pages following this response are the following:

   A Historical Data Chart for UTMC.

   A Projected Data Chart for the requested medical surgical beds.

   A Projected Data Chart for the requested ICU beds.

HISTORICAL DATA CHART
UNIVERSITY HEALTH SYSTEM, INC

	2013	2012	2011
UTILIZATION/OCCUPANCY DATA			
Patient Days	145,140	140,304	141,965
Admissions	27,179	26,236	25,588
REVENUE FROM SERVICES TO PATIENTS			
Inpatient Services	$ 1,034,322,749	$ 937,230,432	$ 880,069,438
Outpatient Services	1,018,516,185	870,308,063	743,807,763
Emergency Services	92,401,748	80,512,914	68,241,021
Other Operating Revenue	36,292,682	36,995,697	36,690,667
GROSS OPERATING REVENUE	2,181,533,364	1,925,047,106	1,728,808,889
DEDUCTIONS FROM OPERATING REVENUE			
Contract Deductions	1,441,202,952	1,261,043,583	1,108,777,267
Provision for Charity Care	49,563,752	30,743,462	32,131,927
Provision for Bad Debt	62,179,073	61,153,134	49,017,030
Total Deductions	1,552,945,777	1,352,940,179	1,189,926,224
NET OPERATING REVENUE	628,587,587	572,106,927	538,882,665
OPERATING EXPENSES			
Salaries and Wages	226,210,720	216,440,445	208,352,621
Physicians' Salaries and Wages	46,764,821	39,500,656	33,327,871
Supplies	164,820,110	139,559,061	125,127,338
Taxes	228,252	252,680	287,252
Depreciation	25,931,840	24,490,737	22,652,789
Rent	7,412,191	6,156,839	5,388,803
Interest, Other than Capital	6,280	4,533	11,800
Management Fees			
Fees to Affiliates	0	0	0
Fees to Non-Affiliates	8,108,002	3,127,263	2,457,722
Other Expenses	131,992,484	126,080,252	119,912,049
TOTAL OPERATING EXPENSES	611,474,700	555,612,466	517,518,245
OTHER REVENUE (EXPENSES) - NET			
Contributions used for purchase of property and equipment	1,922,094	3,606,812	983,710
Investment Income	3,464,115	5,049,548	4,715,736
Change in Fair Value of Interest Rate Swap	(3,929,172)	3,995,761	2,216,165
Unrealized Gain (Losses)	2,435,254	2,909,055	(1,610,159)
TOTAL OTHER REVENUE - NET	3,892,291	15,561,176	6,305,452
NET OPERATING INCOME (LOSS)	$ 21,005,178	$ 32,055,637	$ 27,669,872
Capital Expenditures			
Retirement of Principal	10,998,099	11,339,053	11,664,838
Interest	12,270,742	12,214,135	12,139,210
Total Capital Expenditures	$ 23,268,841	$ 23,553,188	$ 23,804,048
NET OPERATING INCOME (LOSS)	21,005,178	32,055,637	27,669,872
LESS CAPITAL EXPENDITURES	23,268,841	23,553,188	23,804,048
NOI LESS CAPITAL EXPENDITURES	$ (2,263,663)	$ 8,502,449	$ 3,865,824

)THER EXPENSES	2013	2012	2011
'urchased Services	78,739,560	73,271,747	68,172,873
Graduate Medical Education Reimbursement	31,806,637	31,120,692	30,167,311
nsurance	6,644,783	6,917,679	6,863,907
Maintenance and Utility	14,033,136	13,789,116	13,278,203
)ther Expenses	768,368	981,018	1,429,755
	131,992,484	126,080,252	119,912,049

PROJECTED DATA CHART

Acute Care Beds (28)

Give information for the two (2) years following completion of this proposal. The fiscal year begins in January

		Year 1	Year 2
A.	Utilization/Occupancy Data (Inpatient Days and OBS)*	9,198	9,382
B.	Revenue from Services to Patients		
	1. Inpatient Services	$ 52,409,454	$ 53,981,738
	2. Outpatient Services (Observation patients)	$ 11,240,293	$ 11,577,502
	3. Emergency Services	$	$
	4. Other Operating Revenue (Specify) _____	$	$
	Gross Operating Revenue	**$ 63,649,747**	**$ 65,559,239**
C.	Deductions from Operating Revenue		
	1. Contractual Adjustments	$ 43,600,077	$ 45,235,875
	2. Provisions for Charity Care	$ 1,718,543	$ 1,770,099
	3. Provisions for Bad Debt	$ 1,635,798	$ 1,684,872
	Total Deductions	**$ 46,954,418**	**$ 48,690,847**
NET OPERATING REVENUE		$ 16,695,329	$ 16,868,392
D.	Operating Expenses		
	1. Salaries and Wages	$ 8,060,728	$ 8,411,857
	2. Physicians' Salaries and Wages	$ -	$ -
	3. Supplies	$ 6,747,312	$ 6,910,758
	4. Taxes	$ -	$ -
	5. Depreciation	$ 321,338	$ 321,338
	6. Rent	$ -	$ -
	7. Interest, other than Capital	$ -	$ -
	8. Management Fees:	$ -	$ -
	a. Fees to Affiliates	$ -	$ -
	b. Fees to Non-Affiliates	$ -	$ -
	9. Other Expenses	$ 1,095,437	$ 1,128,520
	Specify: _____		
	Total Operating Expenses	$ 16,224,815	$ 16,772,472
E.	Other Revenue (Expenses)--Net		
	Specify: _____		
NET OPERATING INCOME (LOSS)		$ 470,514	$ 95,920
F.	Capital Expenditures		
	1. Retirement of Principal	$ -	
	2. Interest		
	Total Capital Expenditures		$ -
NET OPERATING INCOME (LOSS)		$ 470,514	$ 95,920
LESS CAPITAL EXPENDITURES		$ -	$ -
NOI LESS CAPITAL EXPENDITURES		$ 470,514	$ 95,920

* 7,358 Inpatient days and 1,840 observation patients

PROJECTED DATA CHART

Critical Care Beds (16)

Give information for the two (2) years following completion of this proposal. The fiscal year begins in January

		Year 1	Year 2
A.	Utilization/Occupancy Data (Inpatient Days)	4,672	4,765
B.	Revenue from Services to Patients		
	1. Inpatient Services	$ 40,801,046	$ 42,025,077
	2. Outpatient Services	$ -	$ -
	3. Emergency Services	$	$
	4. Other Operating Revenue (Specify) _____	$	$
	Gross Operating Revenue	**$ 40,801,046**	**$ 42,025,077**
C.	Deductions from Operating Revenue		
	1. Contractual Adjustments	$ 28,152,722	$ 29,207,429
	2. Provisions for Charity Care	$ 1,101,628	$ 1,134,677
	3. Provisions for Bad Debt	$ 1,048,587	$ 1,080,044
	Total Deductions	**$ 30,302,937**	**$ 31,422,150**
NET OPERATING REVENUE		$ 10,498,109	$ 10,602,927
D.	Operating Expenses		
	1. Salaries and Wages	$ 4,767,281	$ 4,942,444
	2. Physicians' Salaries and Wages	$ -	$ -
	3. Supplies	$ 4,429,850	$ 4,547,325
	4. Taxes	$ -	$ -
	5. Depreciation	$ 439,843	$ 439,843
	6. Rent	$ -	$ -
	7. Interest, other than Capital	$ -	$ -
	8. Management Fees:	$ -	$ -
	a. Fees to Affiliates	$ -	$ -
	b. Fees to Non-Affiliates	$ -	$ -
	9. Other Expenses	$ 624,833	$ 643,703
	Specify: _____		
	Total Operating Expenses	$ 10,261,808	$ 10,573,315
E.	Other Revenue (Expenses)--Net		
	Specify: _____		
NET OPERATING INCOME (LOSS)		$ 236,302	$ 29,612
F.	Capital Expenditures		
	1. Retirement of Principal		
	2. Interest		
	Total Capital Expenditures		$ -
NET OPERATING INCOME (LOSS)		$ 236,302	$ 29,612
LESS CAPITAL EXPENDITURES		$ -	$ -
NOI LESS CAPITAL EXPENDITURES		$ 236,302	$ 29,612

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

New Medical Surgical Beds:

Average Gross Charge per day:	$6,919.95
Average Deduction per day:	$5,104.85
Average Net Charge per day:	$1,815.10

New Critical Care Beds:

Average Gross Charge per day:	$8,733.10
Average Deduction per day:	$6,487.07
Average Net Charge per day:	$2,246.03

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Current and proposed charges for the relevant hospital services are reflected below. The charge increases represent normal increases over an approximate two year period, and are not a direct result of this proposal.

University of Tennessee Medical Center

Current vs. Projected Relevant Charge Data

	Current Avg. Total Charge/Day	1st Year Proposed Avg. Total Charge/Day	Current Room & Board Charge/Day	1st Year Proposed Room & Board Charge/Day
NICU Level 1 & 2	6,255	6,442	4,700	4,841
NICU Level 3	6,255	6,442	5,400	5,562
Critical Care	8,733	8,733	2,694	2,694
Acute Care (Inpatient)	7,222	7,222	1,045	1,045

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Comparable average charges of other providers for these services are not available to the applicant. Medicare payments rates for average charges reflected above are likewise not available.

7. **Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.**

As reflected on the Projected Data Chart, both the med/surg and the ICU bed additions will have a positive net operating income in the first year of operation. The margins decrease in the second year, resulting from assumed declining reimbursement rates from government payors. The med/surg unit shows a small operating loss in Year 2. In any event, the Financial Statements reflect sufficient assets to ensure financial viability.

8. **Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.**

As reflected on the Projected Data Chart, both the med/surg and the ICU bed additions will have a positive net operating income in the first year of operation. The margins decrease in the second year, resulting from assumed declining reimbursement rates from government payors. The med/surg unit shows a small operating loss in Year 2. In any event, the Financial Statements reflect sufficient assets to ensure financial viability.

9. **Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.**

UTMC participates in both the Medicare and TennCare programs. UTMC contracts with all TennCare MCOs in the region. In addition, effective January 1, 2015 UTMC will be under contract with AmeriGroup Community Care.

For the whole hospital, the following was the Medicare and TennCare payor mix for the 12 months ending July 31, 2014:

Medicare: 46%

TennCare: 13%

As applied to net revenues on the Projected Data Charts for the Med/Surg beds and the ICU beds, respectively, the estimated revenue from each program are as follows:

Program	Med/Surg	ICU
Medicare:	$7,679,851	$4,829,130
TennCare:	$2,170,393	$1,364,754

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

A copy of audited financials for University Health System, Inc. is attached as Attachment C, II, Economic Feasibility 10. The attached copy does not include the Notes (approximately 25 pages) but the same can be furnished upon request.

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

Over the past several years, UTMC has done all it can, short of adding additional licensed beds, to make more beds available to more patients needing them. This has consisted of moving beds from relatively lower utilized service lines to the higher used lines. It is using all beds for which there is physical space to use. In November it will open an additional 32 beds in the 4th floor of the Heart Hospital.

In addition to the above, UTMC has implemented numerous LEAN and improvement projects to decrease length of stay and increase efficiency in the management of patients. Several of these are reflected below.

LRG / Lean Projects	Year Began (first cycle of A3 / Lean Project)	Current Project (supplemental cycles)
Acute Care - HO to HI	2013	Yes
Critical Care - HO to HI (Incl. ICU Transfers)	2013	Yes
EVS - Bed Turn Around Times	2012, 2013	Yes
NFS – Meal Prep Times (for pts who can D/C after eating)	2014	
Nursing - Outpatient Bedded	2012	
Nursing - Rounding	2013	
Nursing & Case Management - Discharge by 3pm (different scopes: global, 3East)	2012,	Re-launch planned; Active initiative
Mother/Baby Discharge Timeliness	2012	
Laboratory / Phlebotomy – Timeliness / Result Turn Around	2013	

While all of these steps have had some success in maximizing current bed capacity, no realistic alternative remains but to add the beds requested.

b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

Except for the space for the 28 med/surg beds on the 6th Floor of the South Pavilion, which is being renovated, there is no room in the existing structures for the needed beds and NICU expansion. There is no alternative to new construction for these improvements.

(III.) CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. **List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.**

   A list of such agreements is attached as Attachment C, III, Orderly Development 1.

2. **Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition**

arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

The positive effects of this proposal on the area are significant. Patients needing acute care and critical care beds at UTMC will be able to access them on a more consistent basis. Patient holds from the E.D. waiting for an inpatient bed can be greatly reduced. Seriously ill infants in the NICU and their families will have more privacy and comfort during the child's stay in the NICU. And the number of patients who have to be turned away or transferred to other facilities, contrary to their and/or their physicians wishes, can be greatly reduced.

It is difficult to see a negative impact this project will have on the system as a whole, or on any particular provider. While there are of course financial costs involved in implementing the project, UTMC has the funds in cash reserves, and there will be no direct impact on patient charges.

While some patients who are currently forced to be diverted or transferred to other hospitals will be lost to those hospitals, the benefits for the patient outweigh any impact on occupancy rates of those hospitals. The patient and/or the medical care provider, has chosen UTMC as the most appropriate hospital for that patient. It may be due to the specialized services UTMC can provide, it may be for 3rd party payor reasons, or a myriad of other reasons, those choices should be honored if the additional capacity can be added in a responsible and cost efficient manner. This proposal meets those parameters.

3. **Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.**

A proposed clinical staffing chart is reflected below. This staffing pattern matches that of existing bed units of equivalent bed count.

Position – Med Surg Unit	FTE	Wage	Median- D.O.L.W.D.
Manager (RN)	1.00	52.89	$25.65
Team leader (RN)	2.33	40.18	$25.65
Registered Nurse (RN)	22.23	33.29	$25.65
Certified Nursing Assistant (CNA)	11.12	16.74	$10.55
Monitor Tech (MT)	4.45	16.70	Not Listed
Total	41.13		

Position – Critical Care Unit	FTE	Wage	Median- D.O.L.W.D.
Manager (RN)	1.00	52.89	$25.65
Team leader (RN)	4.98	40.18	$25.65
Registered Nurse (RN)	38.25	33.29	$25.65
Certified Nursing Assistant (CNA)	4.78	16.74	$10.55
Total	49.01		

4. **Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.**

   The additional staff that will need to be hired is shown in the immediately preceding response. UTMC is experienced in hiring health care staff, and anticipates no problem in doing so. In its staffing as in all areas of operation, UTMC will maintain compliance with all licensing and accreditation requirements.

5. **Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.**

   The management and executive leadership of UTMC is familiar with all such requirements and is vigilant in keeping up with all revisions, additions and changing interpretations of the same. UTMC will maintain compliance with all licensing and accreditation requirements.

6. **Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.*, internships, residencies, etc.).**

   UTMC has a total of 210 Residents and Fellows (physicians in advanced training seeing patients every day and fulfilling UTMC's as a teaching hospital and training the next generation of physicians). 18 of this number are in Dentistry (10 are in Oral-Maxillofacial Surgery and are essential to the trauma programs). 27 of these Residents/Fellows are supported by funding other than UTMC's Medicare funded allocations. In addition, UTMC participates in training a number of additional clinical specialties. A list of institutions with which UTMC has Educational Affiliation Agreements is attached as Attachment C, III, Orderly Development 6.

7. **(a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.**

   The applicant so verifies.

   (b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

   Licensure: Tennessee Board for Licensing Health Care Facilities

   Accreditation: The Joint Commission. For additional accreditations for UTMC, please see Attachment C, III, Orderly Development 7 (1).

   If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

   UTMC is in good standing with all licensing and accreditation organizations.

   A copy of the hospital license is attached as Attachment C, III, Orderly Development 7 (2).

8. **For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.**

   Because UTMC is accredited by the Joint commission,. It is not routinely surveyed by licensure, but is deemed in compliance by the JC accreditations. A copy of the most recent Joint Commission inspections and accreditations documents s are attached as Attachment C, III, Orderly Development, 8.

9. **Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.**

   There are none.

10. **Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.**

    There are none.

11. **If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.**

    UTMC will do so.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

The Notice of Intent was published in the Knoxville News Sentinel, a newspaper of general circulation in Knox County, on September 10, 2014.

A Publisher's Affidavit is attached following this response.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

   A complete Project Completion Forecast Chart is attached following the Publisher's Affidavit.

2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

   N/A.

To: UT MEDICAL CENTER

(Advertising) NOTIFICATIONOFINTENTTOAPP **(Ref No:** 461168)

PUBLISHER'S AFFIDAVIT

State of Tennessee }

s.s

County of Knox }

Before me, the undersigned, a Notary Public in and for said county, this day pers
first duly sworn, according to law, says that he/she is a duly authorized represent
News-Sentinel, a daily newspaper published at Knoxville, in said county and sta
advertisement of :

(The Above-Referenced)

of which the annexed is a copy, was published in said paper on the following da

September 10, 2014

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that The University of Tennessee Medical Center (UTMC), owned and managed by University Health System, Inc., a Tennessee not-for-profit corporation, intends to file an application for a Certificate of Need for: (1) the expansion and renovation of its Neonatal Intensive Care Unit (NICU) consisting of approximately 9,758 square feet of new construction and 15,432 square feet of renovated space; (2) the addition of approximately 16,850 square feet of new space and renovation of approximately 1,262 square feet of existing space, which will house a new addition to the Intensive Care Unit (ICU); (3) the renovation of approximately 12,000 square feet of existing space to convert it from non-inpatient care space to inpatient rooms; and (4) the addition of 44 acute care beds to its license. Of the 44 requested beds, 28 are anticipated to be allocated as general medical surgical beds, and 16 as ICU beds. UTMC is located at 1924 Alcoa Highway, Knoxville, Knox County, Tennessee, and is licensed as a general acute care hospital by the Tennessee Board for Licensing Health Care Facilities. No changes in services or major medical equipment are involved in this project. The estimated project cost is not to exceed $27,000,000.00.

The anticipated date of filing the application is September 15, 2014.

The contact person for this project is Jerry W. Taylor, Attorney, who may be reached at: Stites and Harbison, PLLC, SunTrust Plaza Suite 800, 401 Commerce Street, Nashville, Tennessee, 37219, 615-782-2228.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

Pursuant to T.C.A. § 68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

and that the statement of account herewith is correct to the best of his/her knowledge, information, and belief.

Susan Ogley

Subscribed and sworn to before me this 10th day of September 2014

Rebecca D Spaun

Notary Public

My commission expires November 2014

STATE OF TENNESSEE NOTARY PUBLIC

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in Rule 68-11-1609(c):
December 2014

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

PHASE	DAYS REQUIRED	ANTICIPATED DATE (Month/Year)
1. Architectural and engineering contract signed	45	February 2015
2. Construction documents approved by the Tennessee Department of Health	180	June 2015
3. Construction contract signed	180	June 2015
4. Building permit secured	180	June 2015
5. Site preparation completed	NA	N/A
6. Building construction commenced	210	July 2015
7. Construction 40% complete	364	December 2015
8. Construction 80% complete	728	December 2016
9. Construction 100% complete (approved for occupancy	910	June 2017
10. *Issuance of license	940	July 2017
11. *Initiation of service	940	July 2017
12. Final Architectural Certification of Payment	940	July 2017
13. Final Project Report Form (HF0055)	970	August 2017

LIST OF ATTACHMENTS

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Filing Information

Name: **UNIVERSITY HEALTH SYSTEM, INC.**

General Information

SOS Control # :	**362499**	Formation Locale:	TENNESSEE
Filing Type:	Corporation Non-Profit - Domestic	Date Formed:	12/21/1998
Filing Date:	12/21/1998 3:08 PM	Fiscal Year Close	12
Status:	Active		
Duration Term:	Perpetual		
Public/Mutual Benefit:	Public		

Registered Agent Address
BENNETT L COX
STE 330
2121 MEDICAL CENTER WAY
KNOXVILLE, TN 37920-3282

Principal Address
BENNETT L. COX
STE 330
2121 MEDICAL CENTER WAY
KNOXVILLE, TN 37920-3282

The following document(s) was/were filed in this office on the date(s) indicated below:

Date Filed	Filing Description	Image #
03/25/2014	2013 Annual Report	A0226-0718
03/27/2013	2012 Annual Report	A0167-2117
	Principal Address 3 Changed From: No value To: BENNETT L. COX	
06/12/2012	Articles of Amendment	7064-1021
04/02/2012	2011 Annual Report	A0115-1467
	Principal Address 1 Changed From: 1520 CHEROKEE TRAIL To: 2121 MEDICAL CENTER WAY	
	Principal Postal Code Changed From: 37920-2205 To: 37920-3282	
	Principal County Changed From: KNOX To: KNOX COUNTY	
	Registered Agent Physical Address 1 Changed From: 1520 CHEROKEE TRL To: 2121 MEDICAL CENTER WAY	
	Registered Agent Physical Postal Code Changed From: 37920-3279 To: 37920-3282	
03/25/2011	2010 Annual Report	A0064-0002
	Principal County Changed From: Knox County To: Knox	
03/25/2010	2009 Annual Report	A0013-0018
03/17/2009	2008 Annual Report	6479-0989
03/28/2008	2007 Annual Report	6267-2056
02/08/2007	2006 Annual Report	5942-2535

Attachment A, 4

Filing Information

Name: **UNIVERSITY HEALTH SYSTEM, INC.**

02/08/2007	Articles of Amendment	5942-2510
03/29/2006	2005 Annual Report	5743-0140
03/31/2005	2004 Annual Report	5410-1020
04/02/2004	2003 Annual Report	5098-0253
	Principal Address Changed	
	Registered Agent Physical Address Changed	
	Mail Address Changed	
03/31/2003	2002 Annual Report	4773-0403
03/26/2002	2001 Annual Report	4459-2072
03/29/2001	2000 Annual Report	4162-0902
01/11/2001	Registered Agent Change (by Entity)	4084-1731
	Registered Agent Physical Address Changed	
	Registered Agent Changed	
06/08/2000	1999 Annual Report	3925-0967
	Principal Address Changed	
	Registered Agent Physical Address Changed	
06/16/1999	Amended and Restated Formation Documents	3693-2465
05/14/1999	Amended and Restated Formation Documents	3685-0593
12/21/1998	Initial Filing	3595-2039

Active Assumed Names (if any)	Date	Expires

CHARTER

OF

UNIVERSITY HEALTH SYSTEM, INC.

Pursuant to the provisions of the Tennessee Nonprofit Corporation Act, the undersigned corporation (the "Corporation") adopts the following Charter:

1. The name of the Corporation is University Health System, Inc.

2. The Corporation is a public benefit corporation.

3. It is intended that the Corporation will qualify at all times as an organization exempt from federal income tax under Section 501(a) and 501(c)(3) of the Internal Revenue Code of 1986 or the corresponding provisions of any future United States Internal Revenue Law (referred to herein as the "Code"), that it will qualify at all times as an organization to which deductible contributions may be made pursuant to Sections 170, 642, 2055 and 2522 of the Code, and that it will qualify as other than a private foundation described in Section 509 of the Code. The Corporation is a public benefit corporation within the meaning of T.C.A. § 48-51-101, et seq. formed for charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Code, including, but not limited to, operating the University of Tennessee Memorial Research Center and Hospital (the "Hospital") in a manner which will fulfill the Hospital's mission statement of dedication to its continuation as the premier center to offer medical care to the underserved population of the thirteen (13) county area served by the Hospital as required by T.C.A. § 49-9-1301; providing health care services for the residents of the region and beyond, including specialized care that is customarily available at academic medical centers; supporting medical research and education; providing a patient base for training physicians, dentists, nurses and other health professionals; supporting clinical research and research training; contracting with, forming joint ventures and partnerships with, and owning interests in other for profit organizations which provide health care services within or as a part of integrated health care delivery systems; and any other activity which supports the delivery of health care services, but only to the extent and in such manner that such purposes constitute exclusively charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Code.

4. The street address of the initial registered office of the Corporation is 9000 Executive Park Drive C-200, Knoxville, Knox County, Tennessee 37923, and the initial registered agent for the Corporation at that office is C.E. Bilbrey, III.

5. The name and address of the incorporator is:

M. Kevin Outterson
1700 Nashville City Center
511 Union Street

Nashville, Tennessee 37219

6. The street address of the principal office of the Corporation is 9000 Executive Park Drive C-200, Knoxville, Knox County, Tennessee 37923.

7. The Corporation is not for profit.

8. The Corporation will not have members. The Corporation shall have no capital stock.

9. The number of directors shall be seventeen (17), and the Board of Directors of the Corporation (the "Board of Directors") shall be comprised of the following persons:

(a) The President of The University of Tennessee, or his designee.

(b) The Chancellor of The University of Tennessee, Memphis, or his designee.

(c) The Dean of The University of Tennessee, Memphis Graduate School of Medicine, or his designee.

(d) The President of University Physicians' Association, Incorporated, or its successor.

(e) The President and Chief Executive Officer of the Corporation.

(f) Two (2) directors appointed by the President of The University of Tennessee and approved by the Board of Trustees of The University of Tennessee who have experience in business, health care management, legal or financial affairs or other qualifications deemed important by the Board of Trustees.

(g) One (1) director who is a past Chief of Staff of the Hospital and who is an active member of the Medical Staff of the Hospital, elected by the Board of Directors from a list of nominees developed by its Nominating Committee.

(h) One (1) director who is a full-time or part-time faculty member of The University of Tennessee, Memphis Graduate School of Medicine and who is an active member of the Medical Staff of the Hospital elected by the Board of Directors from a list of nominees developed by its Nominating Committee.

(i) One (1) director who is a member of University Physicians' Association, Incorporated elected by the Board of Directors from a list of nominees developed by its Nominating Committee.

(j) One (1) director who is not a physician, who is not an employee of The University of Tennessee or the Corporation and who is actively practicing as a licensed healthcare professional, elected by the Board of Directors of the Corporation.

from a list of nominees developed by its Nominating Committee.

(k) Six (6) directors elected by the Board of Directors from a list of nominees developed by its Nominating Committee, who are residents in the Hospital's service area (including all counties from which patients are admitted to the Hospital and all counties wherein the Corporation provides services) not involved in healthcare and who have experience in business, health care management, legal or financial affairs or other qualifications deemed important by the Board of Directors.

Each individual described in (a) through (e) shall hold office for a three (3) year term and shall serve additional terms for so long as such individual holds the position or office designated in (a) through (e); provided, however, that such individuals shall serve only for so long as the individual holds such position, office or designation. Each director described in (f) through (k) shall hold office for a three (3) year term and may be reappointed or reelected for two (2) additional three (3) year terms. The Board of Directors shall divide the directors described in (f) through (k) into three (3) groups of four (4) members each, and determine which of such directors shall serve one, two or three year terms initially. The term of members of the Board of Directors shall begin upon appointment or election.

Each director shall hold office until his successor shall have been duly elected and qualified. This paragraph 8 of the Charter shall not be amended without the prior written consent of The University of Tennessee.

10. The Corporation shall be permitted to indemnify and hold harmless the directors and officers of the Corporation to the fullest extent permitted by Tennessee law as specified in the Bylaws of the Corporation. If the Tennessee Nonprofit Corporation Act is amended or other Tennessee law is enacted to permit further elimination or limitation of the personal liability of directors, then the liability of directors of the Corporation shall be eliminated or limited to the fullest extent permitted by the Tennessee Nonprofit Corporation Act as so amended or by such other Tennessee law as so enacted.

11. To the extent required by Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, (the "Code"): (i) no part of the net earnings of the Corporation may inure to the benefit of any individual except as reasonable compensation for services actually rendered by such individual or as payments and distributions in furtherance of the purposes set forth herein; (ii) no substantial part of the activities of the Corporation shall be carrying on propaganda, or otherwise attempting, to influence legislation (except as permitted by Section 501(h) of the Code); and (iii) the Corporation shall not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office. Notwithstanding any other provision of this Charter, the Corporation shall not carry on any endeavors or activities not permitted to be carried on by a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

12. In the event of permanent dissolution or liquidation, the Board of Directors shall cause the assets of this Corporation to be applied and distributed as follows: (i) all liabilities and obligations of the Corporation shall be paid, satisfied and discharged or adequate provisions shall be made therefor; (ii) all assets held by the Corporation upon a condition which occurs by reason of the dissolution, shall be returned, transferred or conveyed in accordance with such requirements; and (iii) all of the remaining assets of the Corporation shall be transferred or conveyed to The University of Tennessee or to the State of Tennessee. This paragraph 11 of the Charter shall not be amended without the prior written consent of The University of Tennessee.

DATED this 17th day of December, 1998.

M. Kevin Outterson, Incorporator

This Instrument Prepared By:
Baker, Donelson, Bearman & Caldwell
1700 Nashville City Center
511 Union Street
Nashville, Tennessee 37219

LEASE AND TRANSFER AGREEMENT

THIS LEASE AND TRANSFER AGREEMENT is made as of the 8th day of July, 1999 (the "Signing Date"), between **THE STATE OF TENNESSEE**, by and through its **COMMISSIONER OF FINANCE AND ADMINISTRATION** (the "Commissioner") and by and through its instrumentality, **THE UNIVERSITY OF TENNESSEE** (referred to herein as "The University of Tennessee," "UT" or "Lessor") (for and on behalf of **THE UNIVERSITY OF TENNESSEE MEMORIAL RESEARCH CENTER AND HOSPITAL**, the "Hospital," hereinafter defined at Section 1.31 hereof), and **UNIVERSITY HEALTH SYSTEM, INC.**, a Tennessee non-profit corporation (herein referred to as "UHS" or "Lessee").

WITNESSETH:

WHEREAS, UT desires to promote the continued excellence of the Hospital's mission of patient care, education, and research for all citizens served by the Hospital; and,

WHEREAS, the General Assembly of the State of Tennessee has determined that it is in the best interests of UT, the State, and the citizens served by the Hospital to restructure the governance, management, and operation of the Hospital; and,

WHEREAS, the General Assembly of the State of Tennessee passed Enabling Legislation, codified at Tenn. Code Ann. § 49-9-112 and § 49-9-1301 et seq., to accommodate these goals through the transfer of the Hospital to Lessee; and,

WHEREAS, the State, UT and UHS are entering into this Agreement to transfer the Hospital to UHS;

NOW, THEREFORE, IN CONSIDERATION OF THE MUTUAL PROMISES MADE HEREIN, AND FOR OTHER GOOD AND VALUABLE CONSIDERATIONS, THE RECEIPT AND SUFFICIENCY OF WHICH ARE HEREBY ACKNOWLEDGED, IT IS HEREBY AGREED AS FOLLOWS:

ARTICLE I

DEFINITIONS

The following words, terms or phrases, when used in this Agreement, shall have the following meanings:

1.1 "**Affiliated Agreements**" shall mean this Agreement, the Affiliation Agreement, the Employee Services Agreement, and any other agreements, of even date herewith, or which, by their terms, are described therein by the parties as an "Affiliated Agreement" and are signed by all of the parties who execute this Agreement.

1.2 "**Affiliates**" shall include Persons which control, are controlled by, or are under common control of another Person. Control for this purpose means the right to appoint 50% or more of the board of directors (or the equivalent) or rights to 50% or more of the equity of a Person other than an individual.

1.3 "**Affiliation Agreement**" shall mean the Affiliation Agreement executed by and between Lessor and Lessee as of the date hereof providing for the continued support of The University of Tennessee, Memphis Graduate School of Medicine program in Knoxville, a form of which is attached hereto without schedules as Schedule 1.3 and incorporated herein by this reference.

1.4 "**Agreement**" shall mean this Lease and Transfer Agreement.

1.5 "**Assigned Leases and Contracts**" shall mean those contracts, agreements and leases directly related to Existing Facility Operations at Closing and executed by UT solely on behalf of the Hospital.

1.6 "**Assumed Liabilities**" means (a) liabilities of Lessor under the Assigned Leases and Contracts; (b) liabilities arising under executory purchase orders made, and contracts, agreements and leases entered into, by Lessor in the ordinary course of Existing Facility Operations that are outstanding as of the Closing; (c) all accounts payable, obligations and liabilities incurred by Lessor prior to Closing in the ordinary course of Existing Facility Operations; and (d) Prior Legal Liabilities; provided, however, that Assumed Liabilities shall not include any claim for Damages arising out of, attributable to, or in connection with, an occurrence before Closing to the extent Lessee has full or partial immunity from suit on the claim under state or federal law, including without limitation a claim for which jurisdiction properly lies under the Tennessee Claims Commission Act.

1.7 "**Authority**" means the Tennessee State School Bond Authority.

1.8 "**Bill of Sale and Assignment**" shall have the meaning described in Section 13.2(c) of this Agreement.

1.9 "**Board of Trustees**" means the Board of Trustees of The University of Tennessee and its successors.

1.10 "**Bond Indenture**" means the Indenture of Trust dated as of July 1, 1999 between The Health, Educational and Housing Facilities Board of the County of Knox and First Tennessee Bank National Association, and any amendments, additions, substitutions, or replacements thereof.

1.11 "**Bonds**" means the University Health System, Inc. Revenue Bonds, Series 1999, dated July 9, 1999 originally issued in the aggregate principal amount of $ 196,485,000.00, in order to finance the lease of the Facilities and the acquisition of the Operating Assets by Lessee.

1.12 "**Breach**"--- a Breach of a representation, warranty, covenant, obligation, or other provision of this Agreement, or any instrument delivered pursuant to this Agreement, will be deemed to have occurred if there is or has been (a) any inaccuracy in, or breach of, or any failure to perform or comply with, such representation, warranty, covenant, obligation, or other provision, or (b) any claim (by any Person) or other occurrence or circumstance that is or was inconsistent with such representation, warranty, covenant, obligation, or other provision, and the term Breach means any such inaccuracy, breach, failure, claim, occurrence, or circumstance.

1.13 "**Closing**" shall mean July 29, 1999, or the date on which the transactions contemplated in this Agreement are consummated.

1.14 "**Code**" means the Internal Revenue Code of 1986, as amended, and all applicable existing, proposed, and temporary regulations that may from time to time be issued thereunder.

1.15 "**Commissioner**" shall have the meaning described in the recitals.

1.16 "**Consideration**" shall mean the amounts described on Schedule 1.16 of this Agreement; but in any event the amount of Consideration must be approved by the Authority as sufficient to economically defease the Existing Debt. Prior to Closing, this Schedule 1.16 cannot be amended without the approval of the Authority.

1.17 "**CPI**" shall mean the Consumer Price Index for All Urban Consumers, U.S. City Average for all items, as published by the United States Department of Labor, using the year 2000 as the base factor and the current index for the year in question.

1.18 "**Damages**" shall mean the amount of any loss, liability, claim, settlement, award, judgment, release, damage, expense or diminution in value, whether or not involving a third-party claim.

1.19 "**Employee Services Agreement**" shall mean the Employee Services Agreement executed by and between Lessor and Lessee as of the date hereof, a form of which is attached hereto without schedules as Schedule 1.19 and incorporated herein by this reference.

1.20 "**Enabling Legislation**" means Tenn. Code Ann. §49-9-112 and §49-9-1301 et seq., as effective on the date of Closing.

1.21 "**Equipment**" means: (a) all equipment, durable medical equipment, machinery, motor vehicles, ambulances and air ambulances, and furniture owned or leased by Lessor and used in connection with Existing Facility Operations; and (b) all other tangible personal property which is owned or leased by Lessor placed, affixed or installed in, on, to or upon the Real Property which is not included in the definition of Real Property.

1.22 "**Excluded Assets**" shall mean those assets which are set forth in Schedule 1.22 attached hereto and incorporated herein, as adjusted at the Closing by mutual consent.

1.23 "**Excluded Leases and Contracts**" means those agreements of Lessor listed in Schedule 1.23 attached hereto and incorporated herein, as adjusted at the Closing by mutual consent.

1.24 "**Excluded Liabilities**" shall have the meaning described in the Employee Services Agreement.

1.25 "**Existing Debt**" shall mean the existing debt issued by the Authority on behalf of the Hospital, as described in Schedule 1.25.

1.26 "**Existing Facility Operations**" means all of the Hospital, health care, research, patient care, administrative and related activities conducted on the Real Property and at the Henley Street Facility as of the date of Closing hereof by Lessor in the ordinary course of owning and operating the Hospital. Upon the transfer of the Existing Facility Operations to Lessee pursuant to Section 2.2 hereof, the term "Existing Facility Operations" shall mean all of the Hospital, health care, research, patient care, administrative and related activities conducted by Lessee on the Real Property and at the Henley Street Facility during the Term of this Agreement. In all cases, Existing Facility Operations excludes the operation of the Graduate School of Medicine.

1.27 "**Facilities**" means the Hospital, the Real Property, the Henley Street Facility, and all Improvements which are leased by Lessor to Lessee hereunder.

1.28 "**Financial Statements**" shall have the meaning described in Section 3.14 of this Agreement.

1.29 "**Fiscal Year**" means the calendar fiscal year of Lessee which shall begin on January 1 of each year and end on December 31 of such year.

1.30 "**Full Replacement Cost**" has the meaning described in Section 9.2 of this Agreement.

1.31 "**Graduate School of Medicine**" shall have the meaning described in the Affiliation Agreement.

1.32 "**Henley Street Facility**" means the space occupied by the Hospital as of the Signing Date at the UT building located on Henley Street in Knoxville, Tennessee, which is also known as The University of Tennessee Conference Center, as described in Schedule 1.32 attached.

1.33 "**Hospital**" means the facility and institution presently known as The University of Tennessee Memorial Research Center and Hospital located in Knoxville, Tennessee.

1.34 "**Hospital Net Operating Revenue**" shall mean the gross revenue of the Hospital from Existing Facility Operations less contractual adjustments, bad debts and charity care, determined on a US-GAAP basis as certified by the Independent Accountants.

1.35 "**Improvements**" means any and all: (a) buildings, structures, and improvements which have been constructed, placed or installed in or upon the Real Property as of the Signing Date; (b) buildings, structures, and improvements which shall have been made in or upon the Real Property as a substitution for, or in renewal or replacement of, any buildings, structures, and improvements constituting part of the Hospital from the Signing Date until the Closing; or (c) any other additions, alterations and improvements placed or installed in or upon the Real Property prior to the Closing. In any event, Improvements shall not include any Lessee Improvements or Operating Assets.

1.36 "**Independent Accountant(s)**" means a firm of nationally recognized, independent certified public accountants selected by Lessee, which may also be the current auditor of Lessee.

1.37 "**Indicia**" shall mean all trademarks, service marks, trade names, trade dress, logos, Internet domain names, and all names the Facilities (excluding the Henley Street Facility) and Existing Facility Operations are known by, together with all adaptations, derivatives and combinations thereof, including all goodwill associated therewith, and any and all applications, registrations, and renewals in connection therewith (but excluding any marks that have become the exclusive property of UHS before the date of the Closing).

1.38 "**Intellectual Property**" means: (a) the Indicia; (b) all copyrights, and all applications and registrations in connection therewith; (c) all trade secrets and confidential business information, ideas, research and development, know-how, formulas, compositions, processes and techniques, technical data, designs, drawings, specifications, customer and supplier lists, pricing and cost information, and business and marketing plans and proposals; (d) all computer software (including data and related documentation), including all copyrights and other proprietary rights therein; (e) all other proprietary rights; and (f) all copies and tangible embodiments thereof (in

whatever form or medium). Intellectual Property shall only include intellectual property owned by Lessor and used in connection with the Facilities and Existing Facility Operations.

1.39 "**Inventory**" shall mean all supplies and inventory located in the Hospital and used or usable in the Existing Facility Operations, including, without limitation, disposables, consumables, office supplies, drugs and medical supplies, linens, food and cleaning materials.

1.40 "**Involuntary Loss**" has the meaning described in Section 9.5(a) of this Agreement.

1.41 "**JCAHO**" means the Joint Commission on Accreditation of Healthcare Organizations.

1.42 "**Leasehold Mortgage**" shall have the meaning described in Section 11.3(a) of this Agreement.

1.43 "**Leasehold Mortgagee**" shall mean the holder or holders from time to time of a promissory note or notes evidencing a loan and secured by a deed of trust upon the leasehold estate created hereby.

1.44 "**Legal Requirements**" means all federal, state, county, municipal and other governmental statutes, laws, rules, orders, regulations, ordinances, judgments, decrees and injunctions affecting either the Facilities or the construction, use or alteration thereof, whether now or hereafter enacted and in force, including any which may: (a) require repairs, modifications, or alterations in or to the Facilities; or (b) in any way adversely affect the use and enjoyment thereof, and all permits, licenses, authorizations and regulations relating thereto, and all covenants, agreements, restrictions and encumbrances contained in any instruments, either of record or known to Lessee (other than encumbrances created by Lessor without the consent of Lessee), at any time in force affecting the Facilities.

1.45 "**Lessee**" shall have the meaning described in the recitals to this Agreement.

1.46 "**Lessee Improvements**" shall have the meaning described in Section 8.1 of this Agreement.

1.47 "**Lessee Net Operating Profit**" shall mean the net operating profit of UHS determined in accordance with US GAAP, and shall include, without limitation, income from subsidiaries of UHS, from non-Hospital operations of UHS and from investment reserves.

1.48 "**Lessor**" shall mean The University of Tennessee.

1.49 "**Material**" and "**Materiality**" shall mean a condition, noncompliance, defect or other fact which would: (a) cost, in the aggregate, in excess of $100,000.00 and, with respect to any single

defect or fact, would cost in excess of $50,000.00 to correct or repair; or (b) in the aggregate, result in a loss to Lessee or a reduction in the value of the Facilities or Operating Assets in excess of $100,000.00 and, with respect to any single defect or fact, would result in a loss to Lessee or a reduction in the value of the Operating Assets in excess of $50,000.00. For purposes of Section 3.13 of this Agreement only, Materiality shall mean a monetary value in excess of $10,000.

1.50 "**Net Worth Requirement**" shall have the meaning described in Section 9.4(b).

1.51 "**Operating Assets**" means those assets which are owned by Lessor in connection with Existing Facility Operations excluding: (i) the Facilities; and (ii) the Excluded Assets, but including, without limitation:

(a) all Assigned Leases and Contracts;

(b) the Working Capital Assets;

(c) the Equipment;

(d) the Reserve Funds;

(e) the Inventory;

(f) the Intellectual Property, except the Indicia which are licensed to Lessee under Section 2.5 of this Agreement;

(g) all books, records and other information collected and maintained in connection with the Facilities, except the Henley Street Facility, including, without limitation, patient records and copies of UT Hospital Employee records;

(h) all judgments, causes of action and intangibles owned by Lessor and related to the Facilities, except the Henley Street Facility, and Existing Facility Operation;

(i) all permits, licenses, filings, accreditations, certificates of need, authorizations, approvals or indicia of authority (and any pending applications therefor) held by Lessor with respect to the ownership or operation of the Facilities, to own, construct, operate or maintain the Hospital or any fixture, facility, equipment, vehicle, machinery or installation of the Facilities, except the Henley Street Facility, or to operate the businesses conducted in connection therewith, to the extent that each of the foregoing is transferable;

(j) all retainage funds held by Lessor in connection with any ongoing construction projects; and

(k) all assets of Lessor not listed above utilized in Existing Facility Operations that are not otherwise classified as Facilities or Working Capital Assets or that are not Excluded Assets.

Upon the transfer of the Operating Assets to Lessee pursuant to Section 2.2 hereof, the term "Operating Assets" shall mean all Operating Assets received by Lessee plus all accumulations and additions thereto, and less all deletions and deductions therefrom, as may have occurred in the ordinary course of business of Lessee, or as otherwise may have been permitted by the terms of this Agreement.

1.52 "**Permitted Encumbrances**" shall include the Bond Indenture, this Agreement and, as of any particular time with respect to the Facilities (except the Henley Street Facility):

(a) liens for taxes and special assessments, if any, which are not then delinquent, or if then delinquent, are being contested in accordance with the provisions of this Agreement;

(b) utility, access and other easements and rights-of-way, restrictions and exceptions which will not Materially interfere with or Materially impair the operation of the Facilities (excluding the Henley Street Facility) (or, if they are not being then operated, the operation for which they were designed or last modified);

(c) any mechanic's, laborer's, materialman's, supplier's or vendor's lien or right in respect thereof, if any, if payment is not yet due under the contract in question, or if such lien is being contested in accordance with the provisions of this Agreement;

(d) such minor defects and irregularities of title as normally exist with respect to properties similar in character to the Real Property, and which do not Materially and adversely affect the value of the Facilities (excluding the Henley Street Facility), or Materially and adversely affect the value of the Facilities (excluding the Henley Street Facility), or Materially impair the property affected thereby for the purpose for which it was acquired, or is held by Lessee;

(e) leases which relate to portions of the Facilities (excluding the Henley Street Facility) which are customarily the subject of such leases, such as office space for physicians and educational institutions, food service facilities, gift shops, radiology, pharmacy and similar departments, to the extent that such leases will not adversely affect the exclusion from gross income for federal income tax purposes of interest payable on the Bonds;

(f) zoning laws and similar restrictions which are not violated by Lessee or which do not Materially and adversely affect the value of the Facilities;

(g) all right, title and interest of the State, municipalities and the public in and to access over, under or upon a public way;

(h) liens on and security interests in Property given, bequeathed or devised to Lessee existing at the time of such gift, bequest or devise, provided that (i) such liens or security interests attach solely to the Property which is the subject of such gift, bequest or devise, and (ii) the indebtedness incurred by such liens or security interests is not assumed by Lessee or, if assumed, is assumed on a nonrecourse basis;

(i) restrictions or other encumbrances which are either insured over by a reputable, solvent title insurance company which has been writing title insurance in Knox County, Tennessee for at least five (5) years, or which relate to properties which are not contiguous to the Real Property and the loss of which would have no Material adverse impact on the operations of the Hospital;

(j) liens granted in connection with the Bonds or improvements, expansion, extension, additions or modifications of the Facilities (excluding the Henley Street Facility), or improvements of any real property adjacent thereto, or liens granted or leases executed in connection with any replacement Equipment;

(k) any liens, charges, encumbrances and restrictions in favor of Lessor which may be created by reason of this Agreement;

(l) any pledge of Lessee's revenues in connection with Lessee's financing of Improvements to the Facilities (excluding the Henley Street Facility); and

(m) any lien or encumbrance approved by three-fourths of Lessee's Board of Directors.

1.53 "**Person**" shall mean any natural person, corporation (including any non-profit corporation), limited liability company, partnership (general or limited), joint venture, estate, trust, association, charitable organization, labor union, the United States of America, the State, City of Knoxville, Knox County, Tennessee, governmental or quasi-governmental entity of the United States of America, the State, the City of Knoxville, Knox County, Tennessee or any subdivisions thereof, or other business entity or organization.

1.54 "**Prior Legal Liabilities**" shall mean any and all legal liabilities arising or accruing from any act or omission on or before the Closing and in any way arising out of, attributable to or in connection with the Existing Facility Operations. Without limiting the generality and scope of the preceding sentence, Prior Legal Liabilities shall include, without limitation, the following liabilities: professional liability, malpractice liability, tort liability, workers' compensation liability, premises liability, environmental liability, employment discrimination liability, civil rights liability and liability for breach of any constitutional, statutory, common law or contractual duty by Lessor, its agents, trustees, officers and employees on or before the Closing in relation to the Existing Facility Operations, including but not limited to liabilities under the Tennessee Claims Commission Act. "Prior Legal Liabilities" shall not include any Excluded Liabilities or any liabilities relating exclusively to the Graduate School of Medicine or the non-Hospital operations of Lessor.

1.55 "**Property**" means any and all rights, title and interest in and to any and all property whether real or personal, tangible or intangible, of any kind or character, and wherever situated.

1.56 "**Real Property**" means the real property described as Tracts 1 and 2 in Schedule 1.56(a) attached hereto and incorporated herein (as adjusted at the Closing by mutual consent), and all buildings, mechanical systems, driveways, or parking areas located thereon and all rights, easements and appurtenances thereto. A survey of the Real Property, and including Tracts 3, 4, 5, 6, and 7 not leased hereby, is attached hereto as Schedule 1.56(b).

1.57 "**Reserve Funds**" shall mean an amount of money equal to the funded depreciation and other funds (including any interest earned on such funds but not yet credited thereto) designated for capital improvements shown on the Statement of Financial Position of the Hospital as of the Closing.

1.58 "**Service Area**" shall have the meaning described in the Employee Services Agreement.

1.59 "**Signing Date**" shall have the meaning described in the recitals to this Agreement.

1.60 "**State**" means the State of Tennessee.

1.61 "**State Architect**" shall mean the official serving as chief staff officer and operating manager of the State Building Commission.

1.62 "**State Building Commission**" shall mean an agency of the State of Tennessee with the powers and duties described in Tenn. Code Ann. § 4-15-101 et seq.

1.63 "**Tennessee Claims Commission Act**" shall mean Tenn. Code Ann. § 9-8-101, et seq., as amended from time to time or any subsequent enactment governing claims against UT.

1.64 "**Term of this Agreement**", "**Term**", or "**the Term hereof**" means the period commencing on the Closing and expiring fifty (50) years after Closing, July 29, 2049. The parties agree to meet in July 2044 to discuss the terms and conditions of an extension of this Agreement. The Term shall be automatically extended to include an additional fifty (50) years, unless either Lessor or Lessee gives the other written notice of its intention not to extend the Term. Such notice must be delivered between July 1, 2044 and August 1, 2045.

1.65 "**Trustee**" means the Trustee serving from time to time under the Bond Indenture.

1.66 "**UHS**" shall mean University Health System, Inc. and its successors.

1.67 "**UHS Employees**" shall have the meaning described in the Employee Services Agreement.

1.68 "**US GAAP**" shall mean generally accepted accounting principles, as generally applied in the United States.

1.69 "**UT**" shall mean The University of Tennessee, and its successors.

1.70 "**UT Benefit Plans**" shall have the meaning described in the Employee Services Agreement.

1.71 "**UT Hospital Employees**" shall have the meaning described in the Employee Services Agreement.

1.72 "**UT Retirement Plans**" shall have the meaning described in the Employee Services Agreement.

1.73 "**Working Capital Assets**" means cash and cash equivalents (net of petty cash advances), accounts receivable, other receivables, together with inventories, managed care withholds or bonus payments, Authority withholds, prepaid expenses, tax and FICA refunds, withholds, notes receivable and other investments or amounts relating to Existing Facility Operations, and receivables from related parties which are expected to be liquidated in the form of cash and cash equivalents, but excluding all assets financed through long term debt or other long term liabilities. Working Capital Assets also includes any amounts described in this Section 1.73 which are subsequently paid to Lessor but which relate to Existing Facility Operations.

ARTICLE II

LEASE OF FACILITIES; TRANSFER OF OPERATING ASSETS AND EQUIPMENT; ASSUMPTION OF LIABILITIES; CONSIDERATION

2.1 Lease of Facilities; Quiet Enjoyment; Sublease of Tract 2; Right of First Refusal; Easements.

(a) Lessor, for and in consideration of the payment by Lessee of the Consideration, and the performance by Lessee of the covenants and agreements set forth herein, leases and rents the Facilities to Lessee effective as of the Closing, and Lessee takes, accepts and rents the Facilities from Lessor effective as of the Closing, subject to the terms, covenants, conditions and provisions hereinafter stated and the following limitations, restrictions, reservations and encumbrances, to have and to hold for the Term hereof; except that, only with regard to the Henley Street Facility, the rights and responsibilities of Lessor and Lessee shall be as set out in Schedule 2.1(a). Lessee acknowledges that it accepts the Facilities "as is," with no warranty or representation by Lessor as to the condition

of the Facilities and with no obligation of Lessor to repair any known or unknown structural, engineering, design, mechanical, or other defect in the Facilities.

(b) Effective as of the Closing, Lessor agrees that Lessee shall have, hold, and enjoy, during the Term hereof, peaceful, quiet, and undisputed possession of the Facilities, without hindrance or molestation by anyone, and Lessor shall, from time to time, take all necessary or appropriate action to that end.

(c) At Closing, Lessor and Lessee shall enter into a sublease agreement whereby Lessee shall sublease to Lessor, and Lessor shall sublease from Lessee, the real property and improvements described and depicted as Tract 2 in Schedules 1.56(a) and 1.56(b). The terms of such sublease shall be as set forth in the form attached as Schedule 2.1(c).

(d) Lessor and Lessee acknowledge that Tracts 3, 4, 5, 6, and 7 as depicted on the survey attached as Schedule 1.56(b) shall not be included as part of the Real Property leased hereby. As a Material inducement to Lessee's entering into this Agreement, Lessor hereby grants to Lessee a right of first refusal to lease Tract 4 upon the expiration or termination of the existing lease of Tract 4 between Lessor and the Helen Ross McNabb Center. Lessor shall give Lessee written notice of the expiration of such lease within two hundred ten (210) and one hundred eighty (180) days prior to such expiration, and Lessee shall have ninety (90) days after receipt of such notice to notify Lessor whether it intends to lease Tract 4. Upon Lessee's exercise of such right, Tract 4 shall become a part of the Real Property for the remainder of the Term (and any extension thereof) without payment of rent or further consideration to Lessor. Lessor hereby grants to Lessee ingress and egress rights through Tracts 3, 4, 5, 6 and 7 of the Real Property. Lessee hereby grants to Lessor ingress and egress rights through Tracts 1 and 2 for access to Tracts 3, 4, 5, 6 and 7 and to the UT property which adjoins the Real Property on the north.

(e) Lessor hereby grants Lessee an easement over Lessor's property which adjoins the Real Property on the north for the purposes of: (1) the use by Lessee of the existing access road adjacent to the northern boundary of Tract 1 as shown on Schedule 1.56(a) for vehicular, pedestrian and air ambulance ingress and egress, and (2) the use of such airspace as may be reasonably necessary for the operation of Lessee's Lifestar helicopter air ambulance service.

2.2 Transfer of Operating Assets. Lessor, for and in consideration of the payment by Lessee of the portion of the Consideration paid at Closing and effective as of the Closing, assigns, transfers, sells and conveys to Lessee all of Lessor's right, title and interest in and to the Operating Assets. Lessee, during the Term hereof, shall use the Operating Assets so transferred to it in the operation of the Facilities and in furtherance of Lessee's purposes as set forth in its charter, and as otherwise permitted by this Agreement.

2.3 Assumption of Liabilities. Effective as of the Closing, Lessee assumes, and agrees to perform and discharge, all of the Assumed Liabilities as of the Closing; provided that: (a) Lessee shall only assume obligations thereunder to the extent such obligations are enforceable against

Lessor, and, to the extent permitted by law, Lessee shall be entitled to any and all defenses thereunder as were available to Lessor; and (b) Lessor and Lessee each agree to use their respective best efforts to renegotiate or terminate any Assigned Contract such parties mutually agree is not in the best interest of Lessee.

2.4 Consideration. In consideration of the lease of the Facilities and the sale and transfer of the Operating Assets to Lessee hereunder, Lessee agrees to pay to, or at the direction of, Lessor the Consideration. The Board of Trustees shall have sole authority and discretion to determine the distribution of the Consideration within UT. The Consideration shall be in addition to Lessee's obligations to pay or discharge the Assumed Liabilities as specified in Section 2.3 hereof, as adjusted at the Closing by mutual consent. The Consideration shall be allocated to the lease of the Facilities and the sale and transfer of Operating Assets as shall be agreed to by Lessor and Lessee at Closing. In addition, Lessee and Lessor shall enter into the Affiliation Agreement and the Employee Services Agreement. In the year 2019, Lessor and Lessee shall meet to negotiate an annual lease payment for the last thirty (30) years of the Term of this Lease and Transfer Agreement. The amount of any proposed annual lease payment will be based upon the financial position of Lessee at such time and will be subject to prior confirmation from the bond rating agencies which at that time have an active rating on outstanding debt obligations issued by Lessee that the proposed annual lease payment would not result in the withdrawal, suspension or lowering of Lessee's then current bond rating. If Lessee has outstanding insured debt obligations at such time, then the advance written approval by the company or companies which have insured Lessee's debt obligations shall also be required. In any case, any amendment to this Lease and Transfer Agreement pursuant to this Section 2.4 must comply with the terms and conditions of the Enabling Legislation and shall be subject to the prior approval of Lessor's Board of Trustees and Lessee's board of directors.

2.5 License of Indicia. During the Term, Lessee shall have a nonexclusive license to use the Indicia, as they now exist, or as they may be modified during the Term hereof, both internally and/or externally for business, marketing, and promotional activities without payment of a licensing fee, subject to the following provisions: (a) Lessee's use of the Indicia shall satisfy a reasonable standard of quality acceptable to Lessor, and Lessor shall have the right to inspect Lessee's use of the Indicia for the purpose of reasonable quality control; (b) Lessee shall include the trademark (TM) or registered ® symbols in connection with the Indicia as reasonably directed by UT; (c) Lessor shall have the right to approve any and all uses of the Indicia on materials or products for commercial use, and Lessee cannot sublicense the Indicia without the approval of the UT Office of Licensing; (d) Lessee shall not alter any Indicia without the permission of the UT Office of Licensing; (e) Lessor is and shall remain the sole owner of all rights in and to its Indicia as they now exist or may hereafter be modified; (f) Lessee is and shall remain the sole owner of any marks that have become the property of UHS before the date of Closing; (g) Lessee shall be the sole owner of other names, trademarks, service marks, nicknames, and logos which it develops separately whether used alone or in connection with UT Indicia; (h) Lessor shall not grant any license or rights similar to those granted in this Agreement to any other healthcare facility within the Service Area; and (i)

Lessor and Lessee acknowledge each other's rights described in this Section 2.5 and agree not to attack each other's title or ownership to the same. All proposed uses under Section 2.5(c) above shall be submitted to the UT Office of Licensing, and Lessor or any sublicensee shall enter into Lessor's standard licensing agreement with the payment of royalties to Lessor. If the UT Office of Licensing fails to respond to any submission within thirty (30) days of actual receipt, the proposed use for commercial sale shall be deemed approved by Lessor subject to execution of Lessor's standard licensing agreement with the payment of royalties to UT.

ARTICLE III

REPRESENTATIONS AND WARRANTIES BY LESSOR

Lessor makes the following representations and warranties to Lessee as of Signing Date and Closing.

3.1 Organization. Lessor, a land grant institution of higher education, is an instrumentality of the State of Tennessee and is duly organized, validly existing, and in good standing under the laws of the State of Tennessee.

3.2 Power and Authority. Lessor has full power and authority pursuant to the Enabling Legislation to enter into this Agreement, to carry out the transactions contemplated hereunder, and to carry out its obligations hereunder.

3.3 Authorization. Lessor has duly authorized the execution, delivery and performance of this Agreement.

3.4 No Violation. Except as previously disclosed to Lessee in writing, or in any opinions required hereunder, neither Lessor nor the Facilities are subject to any claim or restriction, or are subject to any provision contained in Lessor's statutory provisions, creating, authorizing, or establishing Lessor's existence, Board of Trustees rules, charter, ordinances or bylaws or in any evidence of indebtedness, indenture, commitment, agreement or contract to which Lessor is a party or by which it is bound, or subject to any existing judgment, order or decree binding upon Lessor, which prevents Lessor from entering into this Agreement or performing any of its obligations hereunder.

3.5 Enforceability. This Agreement, and the Affiliated Agreements executed by Lessor of even date herewith, constitute the valid obligations of Lessor in accordance with their respective terms. With respect to these agreements, the State has not waived the Lessor's immunity from suit or extended its consent to be sued. However, current State law provides that monetary claims against the Lessor for breach of its contractual obligations may be heard and determined exclusively in the forum of the Tennessee Claims Commission, an administrative tribunal, where the State may be liable only for actual damages and certain costs.

3.6 Title to Facilities and Operating Assets. Lessor has good and marketable fee simple title to the Real Property and title to the Facilities and Operating Assets, free and clear of any and all encumbrances except for the Permitted Encumbrances.

3.7 Parties in Possession. There are no parties in possession of the Real Property, except for patients at the Hospital and the lessees under the Assigned Leases and Contracts.

3.8 Condemnation. There are no pending or threatened condemnation or similar proceedings against the Real Property or any portion thereof.

3.9 No Litigation. Except as previously disclosed to Lessee in writing, there are no Material claims, actions, suits, arbitrations, license revocations, governmental investigations, inquiries or proceedings pending or, to the best actual knowledge of Lessor, threatened against Lessor, at law or in equity, or before any governmental or administrative board, agency or authority relating to the Existing Facility Operations, Real Property, the Facilities, or Operating Assets, or arising out of the operation or management of the Hospital.

3.10 Finder's or Broker's Fees. Lessor has not engaged any finder or broker in connection with this Agreement or the transaction contemplated hereby, and Lessee is not and will not be obligated for any finder's or broker's fee or commission in connection with this Agreement, or the transactions contemplated hereby, as a result of the actions by Lessor.

3.11 Consents and Approvals. Except as previously disclosed to Lessee in writing, and except for those consents and approvals required by the Enabling Legislation, the execution, delivery and performance of this Agreement, and the consummation of the transactions contemplated by this Agreement, by Lessor will not require any consent, approval, authorization, order, declaration, filing or registration of or with any federal, state or local governmental or regulatory authority (the "Governmental Authorities") or other Person or Persons, and no other action on the part of Lessor or any other Person is necessary to authorize the execution, delivery, and consummation of this Agreement.

3.12 Facilities and Operating Assets. The Facilities and the Operating Assets constitute all the assets currently being utilized by Lessor in connection with Existing Facility Operations.

3.13 Assigned Leases and Contracts.

(a) To the best of Lessor's actual knowledge, the Assigned Leases and Contracts constitute all Material contracts, agreements, purchase orders, leases, subleases, options and commitments, oral or written, and all assignments, amendments, schedules, exhibits and appendices thereof, affecting or relating to the Facilities or any Operating Asset or any interest therein, to which Lessor is a party, or by which Lessor, the Operating Assets or the Facilities is bound or affected, including, without limitation, service contracts, management agreements, equipment leases, office leases and ground or building leases pertaining to any part of the Real Property or Improvements

(other than the Excluded Leases and Contracts). Materiality for the purposes of this Section 3.13 shall mean a monetary value in excess of $10,000.

(b) Except as previously disclosed to Lessee in writing, none of the Assigned Leases and Contracts have been terminated, extended, modified, amended, assigned, transferred or subordinated, and each is in full force and effect and is valid, binding and enforceable in accordance with its respective terms.

(c) To the best of Lessor's actual knowledge, and except as previously disclosed to Lessee in writing: (1) no event or condition has happened or presently exists that constitutes a default or breach or, after notice or lapse of time or both, would constitute a default or breach by any party under any of the Assigned Leases and Contracts; and (2) there are no counterclaims or offsets under any of the Assigned Leases and Contracts.

(d) To the best of Lessor's actual knowledge, there does not exist any security interest, lien, encumbrance or claim of others created or suffered to exist on any of the Assigned Leases and Contracts, except as a Permitted Encumbrance.

(e) Except as previously disclosed to Lessee in writing, none of the Assigned Leases and Contracts shall be amended between the Signing Date and the Closing without the prior written consent of Lessee.

3.14 Financial Statements. The financial statements for Lessor as of June 30, 1998 (i.e., balance sheet, statement of changes in fund balances, statement of current revenues, expenditures and other changes, and accompanying footnotes) will have been provided to Lessee prior to Closing and will include the financial assets and operations for the Hospital. These financial statements are accompanied by the auditor's opinion letter which states that the financial statements present fairly, in all Material respects, the financial position of Lessor as of June 30, 1998. The financial statements have been prepared in accordance with generally accepted accounting principles as prescribed by the Governmental Accounting Standards Board and AICPA College Audit Guide.

3.15 Absence of Certain Changes. Since June 30, 1998, Lessor, as relates to the Hospital, has: (a) not suffered any Material adverse change in the condition, financial or otherwise, business, assets, liabilities or operations which for purposes of this section shall mean in excess of a 15% reduction in net worth or net working capital; (b) not acquired or disposed of any assets except in the ordinary course of business consistent with past practices; (c) not suffered any damage, destruction or loss to any of its properties and assets, whether or not covered by insurance, in excess of $500,000; (d) not written down the value of any assets of Lessor, or written off as uncollectible any accounts receivable of Lessor, except for write-downs and write-offs in the ordinary course of business consistent with past practices; (e) not removed any fixtures, property or Equipment owned or leased by it or any related local medical facility except in the ordinary course of business consistent with past practice; or (f) not agreed, whether in writing or otherwise, to take any action described in this Section 3.15.

3.16 Taxes. With regard to all periods of time through the Closing, Lessor has paid in full all federal and state withholding taxes, unemployment taxes, social security taxes, franchise taxes, payroll taxes, and all other applicable federal, state or local taxes, including, but not limited to, any sales, gross receipts or excise taxes which have or may have an impact on the Facilities or the transaction contemplated by this Agreement, and all penalties and interest with respect thereto, relating to the operations of the Facilities, which were assessed, confirmed, accruable or which relate to the period of time prior to the Closing, or has made satisfactory provision therefor and shall pay such taxes when due if such occurs after the Closing. Any refunds (including interest paid by the taxing authority) on such taxes relating to Existing Facility Operations shall be paid to the Lessee upon receipt. Upon request, Lessee shall receive regular reports from Lessor as to the status of any such pending tax refunds and shall have the right, at its own expense, to participate in any administrative or legal process to recover such taxes from the taxing authority.

3.17 Insurance. Lessor has insurance or self-insurance coverage in effect (including statutory rights to exclusive jurisdiction in the Tennessee Claims Commission) for the Facilities, Existing Facility Operations and all Real Property, operations, personnel, residents, faculty, staff, and assets of an insurable nature and of a character usually insured. Schedule 3.17 attached hereto and incorporated herein (as adjusted at the Closing by mutual consent) contains a true, complete, correct and accurate list and summary description of all such coverage (specifying the insurer, the amount of coverage, any deductibles, the type of insurance, the amount of premiums and dates when they are due, the policy number and any pending claims thereunder, and the expiration date) maintained as aforesaid relating to Lessor. Lessor is not in default or breach with respect to any provision contained in any such coverage, nor has it failed to give any notice or to present any claim thereunder in due and timely fashion. Lessor shall remain responsible for professional liability coverage (including self-insurance) for medical residents and faculty in the Graduate School of Medicine.

3.18 Motor Vehicles. Lessor shall execute in favor of Lessee title certificates for all motor vehicles, ambulances and air ambulances owned by Lessor utilized in Existing Facility Operations.

3.19 Year 2000 Problem. With regard to the possibility that computer programs and systems may not properly process dates subsequent to December 31, 1999 (the "Y2K Problem"), Lessor represents and warrants that its computer systems (including, but not limited to, systems which process wages, salaries and benefits, but excluding computer systems which become property of Lessee under this Agreement or an Affiliated Agreement) are free from the Y2K Problem insofar as it may affect the Hospital, Hospital Employees (as defined in the Employee Services Agreement), other employees of the Hospital, Hospital vendors, and Hospital patients.

3.20 Ongoing Construction. Except as disclosed on Schedule 3.20 attached hereto and incorporated herein, there are presently no ongoing construction or improvement projects on the Real Property having a value exceeding $1,000,000.

3.21 Intellectual Property. No proceedings have been instituted or are pending or, to the best of Lessor's actual knowledge, threatened which challenge the validity of the ownership by Lessor of the Intellectual Property, and Lessor knows of no meritorious basis therefor. To the best of Lessor's actual knowledge, Lessor has not interfered with, infringed upon, misappropriated, or violated any intellectual property, or confidential or proprietary rights of any third party relating to the Intellectual Property. To the best of Lessor's actual knowledge, the Lessor's use of the Intellectual Property does not constitute such infringement, misappropriation or violation and the Lessor has not received any charge, complaint, claim, demand, or notice alleging any such interference, infringement, misappropriation, or violation. Lessor has not granted any license, permission or other authorization to any other person/entity to use such Intellectual Property (other than the Indicia) and Lessor has no actual knowledge of the unauthorized use or infringement of any of such Intellectual Property by any other person/entity. Lessor owns (or possesses adequate and enforceable licenses or other rights to use) all Intellectual Property.

3.22 No Omissions or Misstatements. To the best of Lessor's actual knowledge, there is no fact Material to the assets, liabilities, business or prospects of the Facilities or the Operating Assets which has not been set forth or described in this Agreement, or the Affiliated Agreements, or on the Schedules attached hereto or thereto, which is Material to the business, operations or financial condition of the Facilities. To the best of Lessor's actual knowledge, none of the information included in this Agreement and Schedules, or other documents furnished, or to be furnished, by Lessor, or any of its representatives, contains any untrue statement of a Material fact, or is misleading in any Material respect, or omits to state any Material fact necessary in order to make any of the statements herein or therein not misleading. Copies of all documents referred to in any Schedule attached hereto have been delivered or made available to Lessee, and constitute true, accurate, correct and complete copies thereof, and include all amendments, exhibits, schedules, appendices, supplements or modifications thereto or waivers thereunder.

ARTICLE IV

REPRESENTATIONS AND WARRANTIES BY LESSEE

Lessee makes the following representations and warranties to Lessor as of Signing Date and Closing.

4.1 Organization. Lessee is a non-profit corporation duly incorporated, validly existing, and in good standing under the laws of the State of Tennessee.

4.2 Power and Authority. Lessee has full power and authority to enter into this Agreement, to carry out the transactions contemplated hereunder, and to carry out its obligations hereunder.

4.3 Authorization. Lessee is duly authorized to execute, deliver and perform this Agreement.

4.4 Application for Tax-Exempt Status. Lessee has applied to the Internal Revenue Service to receive a determination that Lessee is an organization described in Section 501(c)(3) of the Code as exempt from federal income tax under Section 501(a) of the Code.

4.5 No Violation. Lessee is not subject to any limitation, restriction or provision of any nature whatsoever contained in Lessee's charter or bylaws, or in any evidence of indebtedness, indenture, commitment, agreement or contract to which Lessee is a party or by which it is bound, or subject to any existing judgment, order or decree binding upon Lessee, which in any way limits, restricts or prevents Lessee from entering into this Agreement or performing any of its obligations hereunder.

4.6 Enforceability. This Agreement, and the Affiliated Agreements executed by Lessee of even date herewith, constitute the legal, valid and binding obligations of Lessee, enforceable in accordance with their respective terms, except insofar as: (a) enforcement may be limited by applicable bankruptcy, insolvency, reorganization, moratorium and other similar laws of general application with creditors; and (b) the remedy of injunctive and other forms of equitable relief may be subject to equitable defenses (including commercial reasonableness, good faith and fair dealing), and to the discretion of the court before which any proceeding therefor may be brought.

4.7 Insurance. Lessee will have insurance coverage in effect for the Existing Facility Operations as required by Article IX of this Agreement.

4.8 No Omissions or Misstatements. To the best of Lessee's actual knowledge, there is no fact Material to the assets, liabilities, business or prospects of the Facilities or the Operating Assets which has not been set forth or described in this Agreement, or the Affiliated Agreements, or on the Schedules attached hereto or thereto, which is Material to the business, operations or financial condition of the Facilities. To the best of Lessee's actual knowledge, none of the information included in this Agreement and Schedules, or other documents furnished, or to be furnished, by Lessee, or any of its representatives, contains any untrue statement of a Material fact, or is misleading in any Material respect, or omits to state any Material fact necessary in order to make any of the statements herein or therein not misleading. Copies of all documents referred to in any Schedule attached hereto have been delivered or made available to Lessor, and constitute true, accurate, correct and complete copies thereof, and include all amendments, exhibits, schedules, appendices, supplements or modifications thereto or waivers thereunder.

4.9 Financial Statements. The pro-forma financial statements for Lessee as of June 30, 1998 (i.e., balance sheet, statement of changes in fund balances, statement of current revenues, expenditures and other changes, and accompanying footnotes) will have been provided to Lessor prior to Closing and will include the financial assets and operations for Lessee.

4.10 No Litigation. Except as previously disclosed to Lessor in writing, there are no Material claims, actions, suits, arbitrations, license revocations, governmental investigations,

inquiries or proceedings pending or, to the best actual knowledge of Lessee, threatened against Lessee, at law or in equity, or before any governmental or administrative board, agency or authority.

ARTICLE V

COVENANTS OF LESSOR AND LESSEE

The following covenants contained in this Article V shall be effective from and after the Signing Date.

5.1 Maintenance of Facilities. Lessor and Lessee shall not, under any circumstances, be required to build or rebuild any Improvements or Lessee Improvements on the Facilities (excluding the Henley Street Facility), or to make any repairs, replacements, alterations, restorations, or renewals of any nature or description to the Facilities (excluding the Henley Street Facility), whether ordinary or extraordinary, structural or non-structural, foreseen or unforeseen, or to make any expenditure whatsoever with respect thereto in connection with this Agreement, or to maintain the Facilities (excluding the Henley Street Facility) in any way; provided, however, Lessee shall maintain Facilities (excluding the Henley Street Facility) which are open to the public or otherwise in use in good and safe repair, in accordance with the standards generally considered as good for medical facilities and hospitals.

5.2 Operation of Facilities. It is intended that Lessee will qualify at all times as an organization exempt from federal income tax under Sections 501(a) and 501(c)(3) of the Code. The Lessee is a public benefit corporation within the meaning of Tenn. Code Ann. § 48-51-101, et seq., formed for charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Code, including, but not limited to, operating the Hospital in a manner which will fulfill the Hospital's mission statement of dedication to its continuation as the premier center to offer medical care to the underserved population of the thirteen (13) county area served by the Hospital as required by Tenn. Code Ann. § 49-9-1301; providing health care services for the residents of the region and beyond, including specialized care that is customarily available at academic medical centers; supporting medical research and education; providing a patient base for training physicians, dentists, nurses and other health professionals; supporting clinical research and research training; contracting with, forming joint ventures and partnerships with, and owning interests in other organizations which provide health care services within or as a part of integrated health care delivery systems; and any other activity which supports the delivery of health care services, but only to the extent and in such manner that such purposes constitute exclusively charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Code.

Subject to: (a) the requirements of the Enabling Legislation and this Agreement; and (b) the terms and conditions of any Affiliated Agreement, Lessee shall have the sole and exclusive charge of the operation of the Facilities (other than the Henley Street Facility), which rights shall include those rights set forth in Article VIII herein.

5.3 Compliance With Applicable Law.

(a) Lessee shall not use, operate or occupy, nor permit any use, operation or occupancy of, the Facilities, or any part thereof, contrary to the Enabling Legislation or Legal Requirements. Lessee also shall observe and comply in all Material respects with the requirements respecting the Facilities of all policies of insurance, or programs of self-insurance, at any time in force, with respect to any of the buildings, Improvements, machinery or Equipment constituting a part of the Facilities.

(b) Nothing in this Section 5.3 shall require Lessee to comply with any law, ordinance, order or governmental regulation so long as there is a substantial and legitimate question as to its applicability to Lessee, or so long as the interpretation or validity of such law, ordinance, order or governmental regulation shall be contested in good faith and by appropriate legal proceedings, including securing any necessary injunctive relief which will stay enforcement of such law, ordinance, order or governmental regulation.

5.4 Liens and Encumbrances. Except for Permitted Encumbrances, Lessee covenants and agrees that it shall not create or suffer to be created any lien, encumbrance or charge upon Lessee's leasehold interest in the Facilities or the Operating Assets and that it will satisfy or cause to be discharged, or shall make adequate provision to satisfy and discharge, within sixty (60) days after the same shall be due, all lawful claims and demands for labor, materials, supplies or other items. Nothing in this Section 5.4 shall require Lessee to satisfy or discharge any such charge, claim or demand so long as the validity thereof shall be contested in good faith by appropriate legal proceedings, and upon posting bond, if required. Lessee covenants and agrees that it is not permitted to create any encumbrance on the Henley Street Facility.

5.5 Tax-Exempt Status.

(a) Lessee covenants and agrees that it will diligently pursue its application filed with the Internal Revenue Service for a determination that Lessee is an organization described in Section 501(c)(3) of the Code. Lessee further covenants and agrees that it shall not perform any act or enter into any agreement which shall adversely affect the federal income tax status of Lessee, and shall conduct its operations and that of the Hospital so as to maintain Lessee's status, once so determined, as a charitable organization within the meaning of Section 501(c)(3) of the Code which is exempt from federal income taxes under Section 501(a) of the Code, or any successor provisions of federal income tax law.

(b) To the extent permitted by law, Lessor and Lessee agree to take such action as the laws of Tennessee permit to ensure that the Facilities are, and remain at all times, during the Term of this Agreement, exempt from ad valorem and other state and local taxation to the maximum extent allowed by law.

5.6 License and Accreditation. Lessee will procure, and maintain in good standing, a license from the State to operate the Hospital as a hospital. Lessee will cause the Hospital to have

JCAHO accreditation throughout the Term of this Agreement, or such accreditation issued by a nationally recognized accrediting body that in the judgment of Lessee's Board of Directors is in the best interest of the Hospital.

5.7 Consents and Notices. Lessor shall use its best efforts to obtain all consents and shall give all notices which may be required in connection with this Agreement, including, without limitation, those required for the transfer of the Assigned Leases and Contracts to Lessee and the assumption by Lessee of the Assumed Liabilities hereunder in accordance with the terms of such agreements and liabilities. Lessor shall provide Lessee with satisfactory evidence that all such Material consents have been obtained and notices have been given upon Lessee's written request.

5.8 Lessor and Lessee Not to Compete. To the extent not prohibited or required by law, Lessor hereby covenants that during the Term of this Agreement, it shall not without the prior written consent of Lessee: (a) construct, fund, own, sponsor, manage or operate any acute-care hospital facility, ambulatory surgical center, physician clinic, emergency or urgent care center, management services organization, managed care company, or any similar facility within one hundred (100) miles of the boundaries of Knox County, Tennessee; or (b) offer, provide or fund any health care related services which compete with the services offered by Lessee or the Hospital as of such date, other than a student health clinic and the activities of the athletics departments.

5.9 Continued Existence. Lessor and Lessee each covenant to continue their respective legal existence, and shall not voluntarily dissolve or take steps to terminate their continued legal existence without the prior written consent of the other.

5.10 Continued Validity of Representations and Warranties. Lessor and Lessee each covenant that they will make reasonable efforts to cause their respective representations and warranties herein to remain true, accurate, correct, and complete during the Term of this Agreement.

5.11 Repayment of Debt. Lessor covenants that it will utilize the Consideration to immediately defease all of the Lessor's and State's debt with regard to the Hospital, the Facilities and the Existing Facility Operations.

5.12 Cooperation. Lessor and Lessee each covenant to: (a) cooperate in the administration of this Agreement and the Affiliated Agreements; (b) execute documents as required to effectuate the transactions contained in this Agreement; (c) make available during normal business hours information necessary to the effective administration of this Agreement; and (d) to hold any such information as confidential to the fullest extent allowed by law. Lessee will maintain permanent records of the disposal of hazardous waste materials generated by Existing Facility Operations before and after Closing. Lessee will make these records available to Lessor for its use in defending any claim against UT arising out of the disposal of hazardous waste materials. Upon termination of this Agreement, Lessee will provide copies of these records to Lessor.

5.13 UT Student Health Clinic Services. Lessee covenants and agrees to continue to provide the patient care services it currently provides to UT students in accordance with the policies and procedures attached as Schedule 5.13.

5.14 Hospital Discount. To the extent permitted by applicable law, Lessee agrees to continue the current discount on inpatient and outpatient Hospital services provided to UT Employees, their spouses and dependent children; provided, however, the discount shall not apply to UT Employees whose beginning date of employment is on or after February 1, 2000.

5.15 Continued Access to the Hospital for all Employees of Lessor. Lessor and Lessee will each use their respective best efforts, working with the State of Tennessee, to allow the Hospital to be included as one of the hospital providers in each health care plan offered to employees of Lessor.

5.16 Post-Closing Gifts, Trusts and Bequests. Lessor and Lessee covenant and agree that after Closing, Lessor will not accept new gifts or bequests for the patient care mission of the Hospital, nor will Lessor manage any gifts or bequests made directly to Lessee. Consistent with its statutory powers, Lessor may serve as the trustee of an inter vivos or testamentary trust created for the benefit of the patient care mission of the Hospital.

5.17 Pre-Closing Gifts, Trusts, and Bequests. Lessor and Lessee covenant and agree that no gift, trust, or bequest made to Lessor up to and including the Closing shall be transferred to Lessee under this Agreement, but if the instrument of gift, trust, or bequest provides that income or corpus shall be used for the patient care mission of the Hospital rather than for the education and research mission of the Graduate School of Medicine, Lessor shall transfer the income or corpus to Lessee in compliance with the terms of the instrument.

ARTICLE VI

LESSOR'S CONDITIONS TO CLOSING

The obligations of Lessor hereunder are, at the option of Lessor, subject to the satisfaction, on or prior to the Closing, of the following conditions, unless waived in writing by Lessor:

6.1 Representations/Warranties. The representations and warranties of Lessee contained in this Agreement shall be true in all Material respects when made and on and as of the Closing as though such representations and warranties had been made on and as of such Closing; and each and all of the terms, covenants and conditions of this Agreement to be complied with or performed by Lessee on or before the Closing, pursuant to the terms hereof, shall have been duly complied with and performed in all Material respects.

6.2 Action/Proceeding. No action or proceeding before a court or any other governmental agency or body shall have been instituted to restrain or prohibit the transactions herein contemplated and no governmental agency or body shall have taken any other action or made any request of Lessee

or Lessor as a result of which Lessor reasonably and in good faith deems it inadvisable to proceed with the transactions hereunder.

6.3 Order Prohibiting Transaction. No order shall have been entered in any action or proceeding before any court or governmental agency, and no preliminary or permanent injunction by any court shall have been issued which would have the effect of: (a) making the transactions contemplated by this Agreement illegal; (b) otherwise preventing consummation of such transactions; or (c) imposing Material limitations on the ability of Lessor effectively to lease the Facilities and sell and transfer the Operating Assets. There shall have been no federal or state statute, rule or regulations enacted or promulgated after the date of this Agreement that would reasonably, directly or indirectly, result in any of the consequences referred to in this Section 6.3.

6.4 Lessee's Deliveries. Lessee shall have delivered to Lessor each of the items specified at Section 13.1.

6.5 Approvals. Each of the approvals required by the Enabling Legislation must have been properly received.

6.6 Insurance. Lessor shall have reasonably consented to the insurance arrangements described in Article IX of this Agreement.

6.7 Legal Opinion. Lessor shall have received a favorable opinion from counsel to Lessee, in a form mutually satisfactory to the Lessor and Lessee.

6.8 Affiliated Agreements. All of the conditions precedent to the obligations of Lessor in each of the Affiliated Agreements must have been satisfied.

ARTICLE VII

LESSEE'S CONDITIONS TO CLOSING

The obligations of Lessee hereunder are, at the option of Lessee, subject to satisfaction, on or prior to the Closing, of the following conditions, unless waived in writing by Lessee:

7.1 Representations/Warranties. The representations and warranties of Lessor contained in this Agreement shall be true in all Material respects when made, and on and as of the Closing, as though such representations and warranties had been made on and as of such Closing; and each and all of the terms, covenants and conditions of this Agreement to be complied with or performed by Lessor on or before the Closing, pursuant to the terms hereof, shall have been duly complied with and performed in all Material respects.

7.2 Licenses and Permits. Lessee shall have reasonable assurances from the State licensing agencies that upon the Closing, licenses to operate the Existing Facility Operations as

currently operated by the Lessor will be transferred to, or reissued in the name of, Lessee. Lessee shall have obtained all other consents, licenses, permits, approvals, determinations or certificates of need required for Lessee to lease and operate the Facilities as contemplated hereby.

7.3 Action/Proceeding. No action or proceeding before a court or any other governmental agency or body shall have been instituted to restrain or prohibit the transactions herein contemplated and no governmental agency or body shall have taken any other action or made any request of Lessee or Lessor as a result of which Lessee reasonably and in good faith deems it inadvisable to proceed with the transactions hereunder.

7.4 Lessor's Deliveries. Lessor shall have delivered to Lessee each of the items specified at Section 13.2.

7.5 Order Prohibiting Transaction. No order shall have been entered in any action or proceeding before any court or governmental agency, and no preliminary or permanent injunction by any court shall have been issued which would have the effect of: (a) making the transactions contemplated by this Agreement illegal; (b) otherwise preventing consummation of such transactions; or (c) imposing Material limitations on the ability of Lessee effectively to lease the Facilities or acquire and hold the Operating Assets. There shall have been no federal or state statute, rule or regulations enacted or promulgated after the date of this Agreement that would reasonably, directly or indirectly, result in any of the consequences referred to in this Section 7.5.

7.6 Due Diligence. Lessee shall be satisfied, in all respects, with the condition of, and title to, the Facilities and Operating Assets, in Lessee's sole discretion.

7.7 Approvals. Each of the approvals required by the Enabling Legislation must have been properly received.

7.8 Financing. Lessee shall have received acceptable financing from a public or private placement of tax-exempt bonds (or, to the extent required by the Code, taxable bonds) issued by Lessee sufficient to fund Lessee's obligations hereunder, at a rate and terms acceptable to Lessee in its sole discretion.

7.9 Title Policy. Lessee shall have received from Lessor a leasehold owner's title policy acceptable to Lessee.

7.10 Legal Opinion. Lessee shall have received a favorable opinion from the UT Office of General Counsel, in a form satisfactory to Lessor and Lessee.

7.11 Affiliated Agreements. All of the conditions precedent to the obligations of Lessee in each of the Affiliated Agreements must have been satisfied.

ARTICLE VIII

IMPROVEMENTS; DISPOSITION OF PROPERTY; SURRENDER

8.1 Lessee Improvements. All buildings, structures, improvements, machinery, equipment and other property which shall be constructed, placed or installed in, or upon, the Real Property after Closing, as an addition to, or as a substitute for, or in renewal or replacement of, any buildings, structures, improvements, furnishings, equipment or other property constituting part of the Facilities (except the Henley Street Facility) on the Real Property (the "Lessee Improvements") shall (unless Lessor and Lessee otherwise provide by signed written agreement directed to a specific item) be excluded from Improvements hereunder without any further act or deed, and nothing herein shall be construed as subjecting real property other than the Real Property, or improvements not located on the Real Property, to the provisions of this Agreement. The Real Property and Improvements shall be completely within the control of Lessee throughout the Term hereof, and Lessee shall have the right at any time to erect, construct, maintain, alter, reconstruct, demolish, build, and replace any Improvements without the permission of Lessor or the State Building Commission, which, by approval of this Agreement, elects, in its sound discretion, not to supervise these projects, subject to the provision set forth in this Section 8.1 below. Prior to the construction of new buildings, addition of square footage to existing buildings, or the complete internal or external demolition of existing buildings, Lessee shall give Lessor and the State Architect, on behalf of the State Building Commission, written notice of such plans at least one hundred and fifty (150) days prior to commencement. Lessor and the State Architect, on behalf of the State Building Commission, shall have sixty (60) days to review and approve or disapprove such plans in order to oversee the general development of the campus, but approval shall not be unreasonably withheld and shall be deemed to have been given unless Lessor or the State Architect, on behalf of the State Building Commission, give written notice to Lessee of objections (stated with specificity) within such sixty (60) day period.

8.2 Disposition of Facilities and Operating Assets. As permitted by Article XI hereof, and otherwise except as may be limited by the Enabling Legislation, Lessee: (i) may freely pledge, mortgage, hypothecate, assign, or sublease its leasehold interest in any of the leased Facilities (except the Henley Street Facility) hereunder; and (ii) may freely transfer, convey, sell, pledge, mortgage, hypothecate, assign, lease, or sublease any Operating Asset transferred hereunder.

8.3 Surrender of Improvements and Lessee Improvements. Upon the expiration of the Term hereof, all Improvements and Lessee Improvements (excluding Operating Assets) located on

the Real Property shall be surrendered to and become the absolute property of Lessor at no cost to Lessor and free and clear of all liabilities, liens, or other encumbrances. Lessee shall execute a bill of sale, deed, or any other documentation reasonably requested by Lessor to confirm the transfer of title to Improvements and Lessee Improvements.

8.4 Easements; Plats. If Lessee, or any Leasehold Mortgagee, determines that it is necessary or advantageous to grant any easement or license of any kind under, over, across or connecting the Real Property or any portion thereof, or to plat or replat the Real Property or any portion thereof, Lessee or any Leasehold Mortgagee shall be entitled to grant easements and execute any plats or replats with respect to its leasehold interest only. Lessor shall cooperate with and execute any applications, permits, plats and other documents as may be necessary or proper for Lessee (a) to be afforded necessary zoning classifications for the Real Property; (b) to have access to any portion of the Facilities (except the Henley Street Facility) not otherwise accessible by public road; (c) to obtain any required governmental approvals of site or building plans for the demolition, construction, improvement, maintenance, use and enjoyment of any Improvements now existing or to be erected on the Real Property (except the Henley Street Facility); or (d) to provide or maintain utility services to the Real Property and any Improvements. No other easements shall be permitted except as described in this Section 8.4.

ARTICLE IX

INSURANCE

9.1 Required Insurance. At all times beginning on Closing and continuing while this Agreement is in effect, Lessee shall maintain, or cause to be maintained, such insurance of the types specified below in amounts and with such deductibles as shall be comparable to coverages carried by institutions possessing, operating and managing assets similar to those being leased to Lessee under this Agreement:

(a) on the Facilities (except the Henley Street Facility): insurance coverage for loss or damage by fire, vandalism and malicious mischief, theft, extended coverage perils commonly known as "All Risk" and all physical loss perils, (including, but not limited to, sprinkler leakage, windstorm, hail, earthquake, tornado, explosion, riot, aircraft, smoke and vehicle damage), in an amount not less than one hundred percent (100%) of the then Full Replacement Cost thereof (as defined below in Section 9.2) with a replacement cost endorsement sufficient to prevent Lessee from becoming a co-insurer together with an agreed value endorsement;

(b) on the Facilities (except the Henley Street Facility): insurance coverage of boilers, pressure vessels, auxiliary piping and selected machinery objects (pumps and compressors);

(c) claims for personal injury or property damage under a policy of comprehensive general liability insurance including, malpractice insurance protecting Lessee against liability for death, injury, loss or damage as a result of, or arising out of, examination, diagnosis, treatment or

care of (or failure to so examine, diagnose, treat or care for) any patient of the Hospital or any occupant of the same, but not limited to insurance against assumed or contractual liability including, any indemnities under this Agreement with amounts not less than Five Million Dollars ($5,000,000) per occurrence and Ten Million Dollars ($10,000,000) aggregate in respect of bodily injury and death, and Ten Million Dollars ($10,000,000) aggregate for property damage (Lessor and Lessee will reevaluate these insurance limits every ten (10) years during the Term of this Agreement to adjust the limits to the then current market conditions);

(d) on the Facilities (except the Henley Street Facility): insurance coverage for flood (when the Facilities are located in whole or in part within a designated flood plain area) and such other hazards and in such amounts as may be customary for comparable properties in the area, and if available from insurance companies authorized to do business in the state in which the Real Property is located, at rates which are economically practicable in relation to the risks covered;

(e) fleet automobile liability insurance in the amount equal to Ten Million Dollars ($10,000,000) combined single limits;

(f) worker's compensation (including, without limitation, coverage for UT Hospital Employees and Lessee Employees) and unemployment coverages as required or permitted by the State and employer's liability in an amount of at least Five Million Dollars ($5,000,000);

(g) builder's risk insurance, completed value form, for the total amount of the construction project, including all change orders therein, during the construction of any Lessee Improvements;

(h) director's and officer's liability insurance in an amount of at least Ten Million Dollars ($10,000,000);

(i) special risk insurance (if applicable); and

(j) environmental risk insurance in an amount of at least Twenty-Five Million Dollars ($25,000,000).

Where feasible, Lessor shall be named as a joint named insured or an additional named insured on such policies, unless Lessor and Lessee mutually agree prior to Closing that the cost of such action is prohibitive.

9.2 Replacement Cost. The term "Full Replacement Cost," as used herein, shall mean replacement cost as defined in the relevent insurance policy.

9.3 Insurers and Policies. All of the policies of insurance referred to in this Article IX shall be written in form satisfactory to Lessor and by insurance companies satisfactory to Lessor. Lessee shall pay all of the premiums therefor, and deliver such policies or certificates thereof to

Lessor prior to their effective date (and, with respect to any renewal policy, at least fifteen (15) days prior to the expiration of the existing policy) and in the event of the failure of Lessee either to effect such insurance in the names herein called for or to pay the premiums therefor, or to deliver such policies or certificates thereof to Lessor at the times required, Lessor shall be entitled, but shall have no obligation, to enact such insurance and pay the premiums therefor, which premiums shall be repayable to Lessor upon written demand therefor, and failure to repay the same shall constitute an event of default. Each insurer mentioned in this Section 9.3 shall agree, by endorsement on the policy or policies issued by it, or by independent instrument furnished to Lessor, that it will give to Lessor thirty (30) days' written notice before the policy or policies in question shall be altered, allowed to expire or canceled.

9.4 Lessee's Right to Self-Insure.

(a) Subject to the terms of Subsection (b) below, and so long as Lessee is not in default under the terms of this Agreement, Lessee shall have the right to self-insure the risks that would otherwise be covered by the insurance required to be maintained by Lessee by the terms of Section 9.1 above. If Lessee desires to exercise its right to self-insure, Lessee shall so notify Lessor and Lessee shall thereupon assume the risks of and shall pay from its assets the costs, expenses, damages, claims, losses, and liabilities relating to injury or death to persons or damage to property, if and to the same extent that a third party insurance company would have paid those amounts if the insurance company were insuring those risks under the policies described in Section 9.1 above.

(b) Notwithstanding anything contained in this Agreement to the contrary, the terms of this Section 9.4 shall only apply if and for so long as Lessee's net worth shall equal or exceed fifty million dollars ($50,000,000), adjusted by the CPI from Closing (the "Net Worth Requirement"). Furthermore, Lessee's right to self-insure shall be exercised only by positive action of Lessee's board of directors. Lessor, at it own discretion, may waive the provisions of this Section 9.4(b) in writing.

(c) Within one hundred twenty (120) days of the end of Lessee's Fiscal Year, Lessee shall cause its certified public accounting firm to issue a letter delivered to Lessor stating whether the Net Worth Requirement has been satisfied and which contains a description of Lessee's self-insurance program.

(d) Lessee shall promptly notify Lessor in writing in the event its net worth falls below the Net Worth Requirement, or if Lessee is required to or elects to terminate its program of self-insurance for any reason whatsoever. That notice shall be accompanied by a certificate of insurance from a third-party insurance company which evidences the existence of the insurance coverage required to be maintained pursuant to the terms of Section 9.1.

9.5 Involuntary Loss; Use of Insurance Proceeds; Condemnation Awards and Sale Proceeds.

(a) If during the Term hereof, all or any part of the Facilities (excluding the Henley Street Facility and Lessee Improvements) shall be damaged or destroyed by whatever cause, or shall be taken by any public authority or entity in the exercise of, or acquired under the threat or the exercise of, the power of eminent domain (for purposes hereof, an "Involuntary Loss"), Lessee shall give prompt notice of such Involuntary Loss to Lessor.

(b) Lessee may repair, rebuild or restore the Facilities (except the Henley Street Facility) damaged, destroyed or taken with such changes, alterations and modifications (including the substitution and addition of other property) as may be desired by it and Lessee may receive the insurance proceeds, condemnation awards or sale proceeds resulting from such Involuntary Loss and shall apply said proceeds for such purpose together with any additional moneys necessary therefor. Any condemnation award relating solely to the underlying fee simple interest owned by Lessor shall be paid to Lessor.

(c) Lessee and Lessor shall cooperate fully with one another in the handling and conduct of any prospective, pending or threatened condemnation proceedings, or with respect to any settlement or negotiation proceedings involving coverage provided under any policy of insurance.

(d) Lessor agrees to take no portion of the Facilities (except the Henley Street Facility) in any condemnation or eminent domain proceeding without Lessee's consent. In the event any portion of the Facilities (except the Henley Street Facility) are acquired in any condemnation or eminent domain proceeding by Lessor or the State, or by conveyance in lieu thereof, the proceeds thereof shall be paid to Lessee and Lessee shall be entitled to claim compensation from the condemning authority for business damages. Any condemnation award relating solely to the underlying fee simple interest owned by Lessor shall be paid to Lessor.

(e) Any balance remaining after completion of the repair, rebuilding or restoration of the Facilities which is attributable to business interruption insurance proceeds shall be paid to Lessee.

(f) Nothing in this Agreement shall be construed as obligating Lessee in any way, or to any extent, to repair, restore or replace the Facilities (except the Henley Street Facility), or any part thereof, except from funds made available as provided in this Article IX.

(g) Notwithstanding anything in this Agreement to the contrary, all funds contemplated in this Article IX shall be paid and disbursed in accordance with the Bond Indenture or any Leasehold Mortgage.

9.6 Failure to Carry Insurance or Self-Insurance. In the event Lessee shall at any time during the Term hereof neglect or refuse to procure or maintain insurance or self-insurance as herein required, Lessor may, at its option, and following at least thirty (30) days' written notice to Lessee, except where a shorter period of written notice is necessary to avoid a default on the Bonds, or to prevent any loss or forfeiture thereof, procure and maintain such insurance, and Lessee shall be

obligated to reimburse promptly Lessor for all amounts expended in connection therewith, and failure to reimburse such amounts shall constitute an event of default.

ARTICLE X

CONTINGENT LIABILITIES

10.1 Survival. The provisions of Section 10.2 and Section 10.3 of this Agreement shall survive the termination of this Agreement and thereafter remain in full force and effect until any right of recovery is barred by any applicable statute of limitation. The provisions of Section 10.4, Section 10.5 and Section 10.6 of this Agreement shall survive the termination of this Agreement and thereafter remain in full force and effect for five (5) years after expiration of the statute of limitations applicable to any claim with respect to which Section 10.4, Section 10.5 and Section 10.6 imposes an obligation on UHS.

10.2 Right of Recovery of Lessee. Lessee shall be entitled to recover from Lessor the amount of any Damages, arising, directly or indirectly, from or in connection with:

(a) any Breach of any representation or warranty made by Lessor in this Agreement or any Affiliated Agreement;

(b) any Breach by Lessor of any covenant or obligation of Lessor in this Agreement or any Affiliated Agreement; or

(c) any payment by Lessee in respect of an Excluded Contract or Lease.

In all cases, Lessee's recovery shall be limited (to the extent applicable) to the terms, limits, and conditions of the Tennessee Claims Commission Act, provided, however, nothing in this Agreement shall permit Lessee to terminate this Agreement upon the happening of any event giving rise to Lessee's right of recovery pursuant to this Article X, its exclusive remedies being those described in Article X herein.

10.3 Right of Recovery of Lessor. Lessor will be entitled to recover from Lessee the amount of any Damages arising, directly or indirectly, from or in connection with: (a) any Breach of any representation or warranty made by Lessee in this Agreement or any Affiliated Agreement; or (b) any Breach by Lessee of any covenant or obligation of Lessee in this Agreement or any Affiliated Agreement; provided, however, nothing in this Agreement shall permit Lessor to terminate this Agreement upon the happening of any event giving rise to Lessor's right of recovery pursuant to this Article X, its exclusive remedies being those described in Article X herein.

10.4 Liability With Respect To UT Hospital Employees. UT Hospital Employees performing services under the Employee Services Agreement are "loaned servants" of UHS. *Respondeat superior* liability for the acts and omissions of UHS Employees and the acts and

omissions of UT Hospital Employees on or after Closing shall lie solely with UHS. All workers' compensation liability for occurrences on or after Closing with respect to UT Hospital Employees shall lie solely with UHS. At all times during the Term of this Agreement, and at its expense, UHS shall provide workers' compensation insurance for UT Hospital Employees in accordance with applicable Tennessee law.

10.5 Protection For UT Hospital Employees. UT and UHS understand and agree that in performing services under the Employee Services Agreement, the UT Hospital Employees are state employees "employed in the service of the state" and their "compensation is payable by the state" within the meaning of Tenn. Code Ann. § 8-42-101(3)(A) and Tenn. Code Ann. § 8-34-101(18). Therefore, UT and UHS understand and agree that the UT Hospital Employees remain eligible to participate in the UT Retirement Plans and other UT Benefit Plans and remain eligible to raise the absolute immunity defense provided in Tenn. Code Ann. § 9-8-307(h) against individual or personal liability for acts or omissions within the scope of their employment. Notwithstanding the above, UT and UHS agree that all *respondeat superior* liability for the acts and omissions of the UT Hospital Employees lies solely with UHS, which will exercise exclusive direction and control over the performance of services by UT Hospital Employees under the Employee Services Agreement. UHS shall indemnify, defend, and hold harmless UT Hospital Employees against all individual or personal liability for Damages arising out of, attributable to, or in connection with, any act or omission of a UT Hospital Employee in the performance of services under the Employee Services Agreement, except for willful, malicious, or criminal acts or omissions, or for acts or omissions done for personal gain.

10.6 Indemnification of UT, State, and UT and State Employees. (a) UHS shall indemnify, defend, and hold harmless UT, the State, and their agents, trustees, officers, employees, and successors against all Damages in any way arising out of, attributable to, or in connection with: (1) the Existing Facility Operations before, on or after the Closing; (2) any act or omission of a UHS Employee or a UT Hospital Employee after the Closing regardless of whether the act or omission relates to the Existing Facility Operations; or (3) any act or omission of a UHS Employee or a UT Hospital Employee before the Closing only if the act or omission relates to the Existing Facility Operations. Without limiting the generality and scope of the preceding sentence, the obligations of UHS under this Section 10.6 shall include, without limitation, the following liabilities: Prior Legal Liabilities, tort liability, worker's compensation liability, premises liability, environmental liability, professional liability, malpractice liability, employment discrimination liability, civil rights liability and liability for breach of any constitutional, statutory, common law or contractual duty. Notwithstanding any provision herein to the contrary, the indemnification and hold harmless obligations of UHS under this Article X with respect to a claim filed under the Tennessee Claims Commission Act for Damages arising out of, attributable to, or in connection with, an occurrence before Closing, and for which jurisdiction lies under the Tennessee Claims Commission Act, shall be limited to the monetary limits of liability established by the Tennessee Claims Commission Act. The indemnification and hold harmless obligation of UHS under this Article X shall be construed as an obligation to pay Damages and not merely as an obligation to reimburse UT, the State, and their agents, trustees, officers, employees and successors for Damages paid by them. The obligations

of UHS under this Article X shall not be deemed or construed to waive or abrogate in any way the sovereign immunity of UT, the State, or any officer or employee of UT or the State.

(b) UHS's obligation under this Article X to defend a claim for Damages filed against UT, the State, or a UT or State employee (including a UT Hospital Employee) in his or her official capacity shall be subject to the following provisions:

(1) All claims filed before Closing and pending as of Closing shall be defended by UT at its own attorney expense.

(2) All claims (i) arising out of, attributable to, or in connection with, an occurrence before Closing and (ii) filed on or after Closing under the Tennessee Claims Commission Act shall be defended by UT. UHS shall pay all UT defense costs, including, without limitation the cost of UT attorney time, at a rate annually agreed upon in writing, and reasonable private attorney fees incurred to assist UT in defending the claim, as agreed upon in writing from time to time.

(3) In the event of a claim (i) arising out of, attributable to, or in connection with, an occurrence before Closing, (ii) filed on or after Closing in a state or federal court or administrative agency, and (iii) against which UT or the State has full or partial immunity from suit under state or federal law, UT or the State shall appear and raise the immunity defense at its own attorney expense. If the claim is not dismissed, UHS shall defend the claim, subject to obtaining any applicable statutory approvals.

(4) In the event of a claim (i) arising out of, attributable to, or in connection with, an occurrence before Closing, (ii) filed on or after Closing in a state or federal court or administrative agency, and (iii) against which UT and the State do not have immunity from suit under state or federal law, UT or the State may elect to defend the claim at its own attorney expense. If UT and the State elect not to defend, UHS shall defend the claim, subject to obtaining any applicable statutory approvals.

(5) In the event of a claim (i) arising out of, attributable to, or in connection with, an occurrence on or after Closing and (ii) filed under the Tennessee Claims Commission Act, UT shall appear and seek dismissal at its own attorney expense. If the claim is not dismissed, UT may elect to defend the claim. In that event, UHS shall pay all UT defense costs, including, without limitation, the cost of UT attorney time, at a rate annually agreed upon in writing, and reasonable private attorney fees incurred to assist UT in defending the claim, as agreed upon in writing from time to time. If UT elects not to defend the claim, UT shall file a petition for removal of the claim to the appropriate chancery or circuit court with venue, pursuant to applicable removal provisions of the Tennessee Claims Commission Act. Upon removal of the claim, UHS shall defend the claim in the chancery or circuit court, subject to obtaining any applicable statutory approvals.

(6) In the event of a claim (i) arising out of, attributable to, or in connection with, an occurrence on or after Closing and (ii) filed in a state or federal court or administrative agency, UT or the State may elect to appear and seek dismissal at its own attorney expense. If UT and the State elect not to appear and seek dismissal, or the claim is not dismissed, UHS shall defend the claim, subject to obtaining any applicable statutory approvals.

(c) In accordance with its indemnification and hold harmless obligations under this Article X, UHS shall pay all Damages under a claim defended by UT or the State pursuant to Section 10.6(b); provided, however, that the obligation of UHS to pay attorney expenses of UT and the State shall be limited by applicable provisions of Section 10.6(b). Notwithstanding any provision of Section 10.6 to the contrary, UHS shall have the right to participate in the defense of any claim for Damages for which it may become liable under this Agreement or applicable law; provided, however, UHS understands and agrees that under current law, UHS is not entitled to appear and defend a claim under the Tennessee Claims Commission Act.

(d) UT and the State shall have the right, through legal counsel, to monitor and review the defense by UHS of any claim for Damages in which UT, the State, or UT or State employees in their official capacities are named as defendants. UHS shall obtain the approval of legal counsel for UT or the State prior to raising sovereign immunity or other legal defenses on behalf of UT, the State, or UT or State employees in their official capacities. UHS shall not raise the defense of sovereign immunity as to any claim for Damages against UHS, its agents, officers, directors, employees or successors if the claim arose out of, was attributable to or was in connection with any act or omission on or after Closing by UHS, its agents, officers, directors, employees or successors. Nothing herein shall be construed to prohibit UHS from raising the defense of sovereign immunity as to any claim arising out of, attributable to or in connection with an act or omission by UT, the State or a UT or State employee, as long as the defense would have been properly raised by UT, the State, or a UT or State employee.

(e) Nothing in this Section 10.6 shall be construed to obligate UHS to indemnify, defend and hold harmless a UT Hospital Employee against individual or personal liability for Damages arising out of, attributable to, or in connection with, willful, malicious, or criminal acts or omissions, or acts or omissions done for personal gain.

10.7 Injunctive Relief. In addition to the other remedies described in this Article X, to the extent permitted by law, the parties may pursue injunctive relief with a court of competent jurisdiction for enforcement of the provisions of this Agreement; provided however that injunctive relief against UT or the State shall be available, if at all, only pursuant to the provisions of the Tennessee Claims Commission Act.

ARTICLE XI

FINANCING

11.1 Lessee's Right to Obtain Financing. At any time, and from time to time, during the Term hereof, Lessee shall have the sole responsibility for obtaining, and the right and privilege to obtain, and shall be entitled to all proceeds of, all financing (including, without limitation, interim, permanent, capital improvements, and equity) secured by or benefitting the Facilities, or any part thereof, and all refinancing of all or any part of such financing (interim, permanent, capital improvements, and equity), subject to the terms and conditions of this Article XI.

11.2 Limitations on Financing. Lessee's rights to obtain such financing and refinancing shall be subject only to the following conditions:

(a) The Person providing any such financing or refinancing shall agree that Lessor shall not be liable for the payment of such indebtedness or the performance of any of the covenants contained in the documents securing payment thereof; provided, however, subject to the requirements of the Enabling Legislation, that the above provisions shall not be deemed to exculpate Lessor from any liability it may ever have to such mortgagee, as the successor-in-interest of the Lessee hereunder, by reason of Lessor's covenants, obligations, and warranties set forth herein, including, but not limited to, Landlord's warranty of title to the Facilities (except the Henley Street Facility).

(b) The Person providing any such financing or refinancing shall agree to give Lessor written notice of any default by Lessee thereunder and time to cure such default prior to the exercise of any remedies such Person may have with respect to the Facilities (except the Henley Street Facility) as a result of such default, which notice and time-to-cure periods shall not be less than the notice and time-to-cure periods granted to Lessee under the documentation evidencing such financing, but which may run concurrently therewith. Lessor shall have no obligation to cure any such default, but any cure performed by Lessor shall constitute an indebtedness of Lessee to Lessor hereunder and shall be repayable to Lessor upon written demand therefor, and moreover, failure to repay same shall constitute an event of default.

11.3 Rights of Leasehold Mortgagee.

(a) In addition to the financing or refinancing permitted pursuant to Sections 11.1 and 11.2 hereof, and subject to the limitations of Section 11.2, Lessee shall have the right at any time, and from time to time, without Lessor's consent, to mortgage, pledge, grant deed(s) of trust, or otherwise encumber the leasehold estate created hereby and all or any portion of the right, title, and interest of Lessee hereunder (defined herein as a "Leasehold Mortgage"), and to assign, hypothecate, or pledge the same, as security for the payment of any debt to any Leasehold Mortgagee; provided that no mortgagee, trustee, or other Person claiming by, through, or under any instrument creating any such encumbrance on the leasehold estate created hereby, shall by virtue thereof, acquire any

greater right in the Real Property than Lessee then had under this Agreement, except for the rights expressly granted to such mortgagee, trustee, purchaser at foreclosure, or other Person under the terms of this Agreement; and provided, further, that such mortgage, deed of trust, or other instrument encumbering the leasehold estate created hereby, and the indebtedness secured thereby, shall at all times be, and remain subject to, all of the conditions, covenants, and obligations of this Agreement and to all of the rights of Lessor hereunder. As to any such Leasehold Mortgage in favor of a Leasehold Mortgagee, Lessor consents to provisions therein, at the option of Lessee upon default of Lessee under the Leasehold Mortgage: (i) for an assignment of Lessee's share of the net proceeds from any award or other compensation resulting from a total or partial taking as set forth in Article IX of this Agreement; (ii) that a default by Lessee under this Agreement shall constitute a default under any such Leasehold Mortgage; (iii) for an assignment of Lessee's right, if any, to terminate, cancel, modify, change, supplement, alter, or amend this Agreement; (iv) for an assignment of any sublease to which any such Leasehold Mortgage is subordinated, subject to the rights of Lessor hereunder; and (v) effective upon any default in any such Leasehold Mortgage: (A) for the foreclosure of the Leasehold Mortgage pursuant to a power of sale or by judicial proceedings or other lawful means, and the subsequent sale of the leasehold estate to the purchaser at the foreclosure sale and a sale by such purchaser and/or a sale by any subsequent purchaser; (B) for the appointment of a receiver, irrespective of whether any Leasehold Mortgagee accelerates the maturity of all indebtedness secured by the Leasehold Mortgage; (C) for the rights of the Leasehold Mortgagee or the receiver to enter and take possession of the Real Property, to manage and operate the same, to collect the subrentals, issues and profits therefrom (subject to the terms of this Agreement), and to cure any default under the Leasehold Mortgage or any default by Lessee under this Agreement; and (D) for an assignment of Lessee's right, title, and interest in and to the premiums for, or dividends upon, any insurance with respect to the Facilities (except the Henley Street Facility), as well as in all refunds or rebates of real estate taxes or assessments upon or other charges against the Facilities (except the Henley Street Facility), whether paid or to be paid, under a default of Lessee under the Leasehold Mortgage. The parties recognize and agree that Tennessee Code Annotated Section 49-9-1301(b)(2) does not apply to any conveyance permitted by this Section 11.3.

(b) If at any time after the execution and recordation of any such Leasehold Mortgage, the mortgagee or trustee therein shall notify Lessor in writing that any such Leasehold Mortgage has been given and executed by Lessee, and shall at the same time furnish Lessor with the address to which it desires copies of notices to be mailed, Lessor hereby agrees that it will thereafter mail to such mortgagee or trustee at the address so given, duplicate copies of any and all notices in writing which Lessor may from time to time give or serve upon Lessee under and pursuant to the terms and provisions of this Agreement.

11.4 Liability of Leasehold Mortgagee. No Leasehold Mortgagee shall be or become liable to Lessor as an assignee of this Agreement or otherwise until it expressly assumes by written instrument such liability, and no assumption shall be inferred or result from foreclosure or other appropriate proceedings in the nature thereof or as the result of any other action or remedy provided for by any mortgage or deed of trust or other instrument executed in connection with such Leasehold

Mortgage or from a conveyance from Lessee pursuant to which the purchaser at foreclosure or grantee shall acquire the rights and interests of Lessee under the terms of this Agreement.

11.5 No Encumbrances by Lessor. Lessor will not at any time, without the prior written consent of Lessee, which consent may be withheld with or without cause, encumber by mortgage, deed of trust, security agreement, easement, or other instrument in the nature thereof, the Facilities (except the Henley Street Facility) or any part thereof, or any of Lessor's right, title, or interest therein or in any part thereof.

ARTICLE XII

MISCELLANEOUS

12.1 Governing Law. This Agreement is made, entered into under, and shall be construed in accordance with, the laws of the State of Tennessee.

12.2 Non-Binding Mediation. In the event a dispute between the parties relating to this Agreement, or the Breach thereof, and if said dispute cannot be settled through negotiation, the parties (including senior management for Lessor and Lessee) hereto agree to attempt in good faith to settle the dispute by non-binding mediation under non-binding mediation rules mutually acceptable to both Lessor and Lessee. The parties must participate in good faith in non-binding mediation, before resorting to some other dispute resolution procedure.

12.3 No Waiver. Subject to the provisions of the Tennessee Claims Commission Act, a party's failure to respond to a Breach by the other party shall not operate as a waiver of their rights under this Agreement or otherwise. Any delay or omission by a party in its exercise of any right or power accruing upon any Breach shall not impair or constitute a waiver of such right or power by that party and any such right or power may be exercised from time to time and as often as may be deemed expedient. No act or omission of either party shall constitute a waiver of any provisions of this Agreement unless the waiver has been agreed to in writing by the party granting the waiver.

12.4 Notice. Notice must be given in writing (including facsimile, but not electronic mail) which identifies itself as a notice under this Agreement. Notice is effective on the date which is the later of: (a) the actual date received; (b) five (5) business days after the notice is deposited with the U.S. Postal Service, postage prepaid, certified mail, return receipt requested; or (c) three (3) business days after the notice is deposited prepaid with a national overnight package delivery service for overnight delivery. Notice must be given to the following addresses unless the parties have given prior notice of a change of address:

(A) If to Lessor:

President
The University of Tennessee
800 Andy Holt Tower
Knoxville, Tennessee 37996

with a copy to:

General Counsel
Office of the General Counsel
The University of Tennessee
700 Andy Holt Tower
Knoxville, Tennessee 37996

(B) If to Lessee:

President and CEO
University Health System, Inc.
The University of Tennessee Medical Center
at Knoxville
1924 Alcoa Highway
Knoxville, Tennessee 37920

with a copy to:

M. Kevin Outterson, Esq.
Baker, Donelson, Bearman & Caldwell
1700 Nashville City Center
511 Union Street
Nashville, Tennessee 37219

(C) If to the State:

Commission of Finance and Administration
First Floor, State Capitol
Nashville, Tennessee 37243
Attention: Commissioner

with a copy to:

Office of the General Counsel
The University of Tennessee
719 Andy Holt Tower
Knoxville, Tennessee 37996
Attention: General Counsel

(D) If to Bond Indenture Trustee:

First Tennessee Bank National Association
511 Union Street, 3rd Floor
Nashville, Tennessee 37219-1736
Attention: William F. McCormick

with a copy to: Stokes & Bartholomew, P.A.
424 Church Street, Suite 2800
Nashville, Tennessee 37219-2386
Attention: Cynthia Mitchell Barnett

12.5 Entire Agreement. This Agreement, together with the Schedules attached hereto and the Affiliated Agreements, constitutes the entire understanding between the parties hereto regarding the subject matter of this Agreement. Any prior oral or written agreements, promises, negotiations or representations relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

12.6 No Third-Party Beneficiaries. This Agreement does not confer any benefit or right upon any Person other than the parties hereto, and no party claiming third-party beneficiary status shall be entitled to enforce any obligations, responsibility or claim of any party to this Agreement.

12.7 Nonassignment. This Agreement may not be assigned by the Lessee without the express prior written consent of the Lessor; except that the Lessee may assign this Agreement to Affiliates, including a parent, subsidiary, or brother-sister corporation created pursuant to the Enabling Legislation, without the consent of the Lessor.

12.8 Article and Section Headings. All article and section headings are included for convenience only and shall not be considered a part of nor shall they affect in any manner the construction or interpretation of this Agreement.

12.9 Severability. If any one or more of the sentences, sections or other portion of this Agreement shall be determined by a court of competent jurisdiction to be invalid, the invalidity of any such sentence, section or other portion of this Agreement shall in no way affect the validity or effectiveness of the remainder of this Agreement, and this Agreement shall continue in force to the fullest extent permitted by law.

12.10 Amendment. This Agreement may only be amended by a written agreement duly executed by Lessee and Lessor.

12.11 Covenants Considered Material. All covenants made by Lessor or Lessee herein shall be considered to be Material to the Agreement.

12.12 Multiple Counterparts. This Agreement may be executed in multiple counterparts, each of which shall be regarded for all purposes as an original constituting but one and the same instrument.

12.13 No Personal Liability. Notwithstanding anything to the contrary contained herein, or in any Affiliated Agreement, no stipulation, covenant, agreement or obligation contained herein or therein shall be deemed or construed to be a stipulation, covenant, agreement or obligation of any

present or future member, director, trustee, affiliate, officer, employee or agent of Lessor or Lessee or of any incorporator, member, director, trustee, affiliate, officer, employee or agent of any successor to Lessor or Lessee, in any such person's individual capacity, and no such person, in his individual capacity, shall be liable personally for a breach or nonobservance of or for any failure to perform, fulfill or comply with any such stipulations, covenants, agreements or obligations, and all such liability of any such person, in his individual capacity, is hereby expressly waived and released.

12.14 Good Faith. Good faith is the essence of this Agreement. Lessor and Lessee each agrees to exercise good faith and commercial reasonableness in the interpretation, performance and enforcement of this Agreement.

12.15 Auditing Records. Lessee shall maintain documentation for all charges against the State or Lessor under this Agreement. The books, records, and documents of Lessee, insofar as they relate to work performed or money received under this Agreement, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit, at any reasonable time, and upon reasonable notice, by the State, the Comptroller of the Treasury, Lessor, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

12.16 Consents and Approvals. Whenever the written consent or approval of Lessor or Lessee or any officer thereof, shall be required under the provisions of this Agreement, such consent or approval shall not be unreasonably withheld, conditioned, or delayed.

12.17 Recording. The parties agree that a short form memorandum of this Agreement, in customary form, may be recorded in the Register's Office for Knox County, Tennessee.

12.18 Relationship of Parties. Nothing contained in this Agreement shall be construed or deemed by the parties hereto or by any third-party to create a relationship of partnership or of joint venture or of any association whatsoever between and among Lessor and Lessee.

12.19 Time is of the Essence. Time is of the essence in the performance by each party of its obligations hereunder.

12.20 No Merger. There shall be no merger of this Agreement or of the leasehold estate created hereby by reason of the fact that the same person or Person may acquire, own or hold, directly or indirectly: (a) this Agreement or the leasehold estate created hereby or any interest in this Agreement or such leasehold estate; and (b) the fee estate in the Real Property.

ARTICLE XIII

DELIVERIES

13.1 Deliveries to Lessor. Simultaneously with the Closing (or, when so noted, simultaneously with the Signing Date), Lessee shall deliver the following to Lessor:

(a) Certified Resolutions of Lessee. Resolutions of the Boards of Directors of Lessee, duly certified as of the date hereof by the Secretary of Lessee, authorizing the execution, delivery and performance of this Agreement and the Affiliated Agreements by Lessee. This resolution shall be delivered on the Signing Date.

(b) Affiliated Agreements. The Affiliated Agreements executed by a duly authorized officer of Lessee. These deliveries shall be made on the Signing Date.

(c) Legal Opinion. An opinion of counsel for Lessee in form and substance satisfactory to Lessor and Lessee concerning the Lessee's representations and warranties made hereunder.

(d) Schedules. The Schedules described in this Agreement which are the responsibility of Lessor, correct and complete when given and as of the Closing.

(e) Other Instruments. Such other instruments, certificates and other documents as may be reasonably requested by Lessor to effectuate the transactions contemplated by this Agreement.

13.2 Deliveries to Lessee. Simultaneously with the Closing (or, when so noted, simultaneously with the Signing Date), Lessor shall deliver the following to Lessee:

(a) Certified Resolutions of Lessor. Resolutions of the Board of Trustees of Lessor, duly certified as of the date hereof by the secretary of the Board of Trustees, authorizing the execution, delivery and performance of this Agreement by Lessor. This resolution shall be delivered on the Signing Date.

(b) Affiliated Agreements. The Affiliated Agreements authorized by a duly authorized officer of Lessor and, where applicable, the State. These deliveries shall be made on the Signing Date.

(c) Bill of Sale and Assignment. A Bill of Sale and Assignment in the form attached hereto and incorporated herein (as adjusted at the Closing by mutual consent) as Schedule 13.2(c) warranting and conveying to Lessee good, valid, and marketable title to the Operating Assets free and clear of all liens, mortgages, pledges, encumbrances, security interests, covenants, restrictions, defects in title, and other burdens, except for the Permitted Encumbrances.

(d) Certificates of Title. Certificates of title to all motor vehicles that constitute Equipment endorsed by Lessor, together with completed originals of any forms required by the State to transfer the same, free and clear of all liens.

(e) Assignment of Leases and Contracts. An effective and enforceable assignment to Lessee of those Assigned Leases and Contracts as Lessee shall designate.

(f) Legal Opinion. A favorable opinion from the UT Office of General Counsel, in a form mutually satisfactory to Lessor and Lessee.

(g) Schedules The Schedules described in this Agreement which are the responsibility of Lessee, correct and complete when given and as of the Closing.

(h) Approvals. Certified evidence of the approvals required under the Enabling Legislation.

(i) Other Instruments. Such other instruments, certificates and other documents as may be reasonably requested by Lessee to effectuate the transactions contemplated by this Agreement. This provision shall survive the Closing.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed under seal as of the day and year first above written.

Lessor:

THE UNIVERSITY OF TENNESSEE

By: _____
Title: President

Attest:

By: Karen M. Moore
Title: Notary Public

Lessee:

UNIVERSITY HEALTH SYSTEM, INC.

By: _____
Title: President & CEO

Attest:

By: Karen M. Moore
Title: Notary Public

State:

THE STATE OF TENNESSEE, BY AND THROUGH ITS COMMISSIONER OF FINANCE AND ADMINISTRATION

By: _____
Title: Commissioner

Attest:

By: Karen M. Moore
Title: Notary Public

Approved:

THE ATTORNEY GENERAL OF THE STATE OF TENNESSEE

Approved:

THE GOVERNOR OF THE STATE OF TENNESSEE

ACKNOWLEDGMENT

STATE OF TENNESSEE
COUNTY OF Davidson

Before me, Karen M. Moore, a Notary Public in and for the State and County aforesaid, personally appeared Joseph E. Johnson, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself (or herself) to be the President of THE UNIVERSITY OF TENNESSEE, the within named bargainor, a State Agency, and that he as such President, being duly authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the university by himself as such President.

WITNESS my hand and seal at office, on this the 8th day of July, 1999.

Karen M. Moore
Notary Public

My Commission Expires:

May 28, 2000

M JMB 250246.26
786593-010 07/07/99

ACKNOWLEDGMENT

STATE OF TENNESSEE
COUNTY OF Davidson

Before me, Karen M. Moore, a Notary Public in and for the State and County aforesaid, personally appeared C. E. Bilbrey, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself (or herself) to be the President & CEO of **UNIVERSITY HEALTH SYSTEM, INC.**, the within named bargainor, a corporation, and that he as such President & CEO, being duly authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself as such President & CEO.

WITNESS my hand and seal at office, on this the 8th day of July, 1999.

Karen M. Moore
Notary Public

My Commission Expires:

May 28, 2000

SCHEDULE 1.56(a)

REAL PROPERTY

BOUNDARY DESCRIPTIONS

BEING SITUATED IN DISTRICT NO. 9, KNOX COUNTY, TENNESSEE, AND WARD NO. 24 OF THE CITY OF KNOXVILLE, AND BEING MORE PARTICULARLY BOUNDED AND DESCRIBED BASED ON DRAWING NO. 98144 BY URBAN ENGINEERING, INC., FARRAGUT, TN, AS FOLLOWS:

TRACT 1

Beginning at a concrete right of way monument in the northeastern right of way line of Cherokee Trail at the intersection of said line with the southeastern right of way line of Old Cherokee Trail, said monument having Tennessee Lambert Grid Co-ordinates N590,364.5; E 2,577,930.2; thence, from said point of beginning with the right of way line of Old Cherokee Trail, eight consecutive calls as follows:

1. N34°56'E 145.63 feet to an iron pin;
2. With the arc of a curve to the left 203.00 feet to a P.K. nail, said curve having a radius of 300.04 feet and a chord of N16°49'E, 199.15 feet;
3. N2°34'W 20.05 feet to an iron pin;
4. S87°26'W 80.00 feet to an iron pin, said pin being defined as Point 'A' for further reference herein;
5. S2°34'E 20.05 feet to an iron pin;
6. with the arc of a curve to the right 148.88 feet to a P.K. nail, said curve having a radius of 220.04 feet and a chord of S16°49'W 146.05 feet;
7. S36°12'W 129.74 feet to an iron pin;
8. N89°02'W 31.49 feet to a drill hole in a concrete curb;

thence, with the northern right of way line of Cherokee Trail, a total of seven consecutive calls, as follows:

9. with the arc of a curve to the left 317.14 feet to an iron pin, said curve having a radius of 714.81 feet and a chord of N72°35'W 314.54 feet;
10. N82°48'W 114.71 feet to a P.K. nail;
11. S80°41'W 599.77 feet to an iron pin;
12. S85°39'W 277.15 feet to an iron pin;
13. with the arc of a curve to the right 99.42 feet to an iron pin, said curve having a radius of 329.26 feet and a chord of N85°42'W 99.04 feet;
14. N55°09'W 140.19 feet to an iron pin;
15. N82°25'W 256.16 feet to an iron pin;

thence, with a line which is the common boundary of property of the University of Tennessee further described herein as Tract 2, a total of two consecutive calls as follows:

16. N8°52'W 310.00 feet to an iron pin;
17. N30°33'E 1177.52 feet to an iron pin;

thence, severing remaining property of the University of Tennessee, generally following the south edge of an existing driveway, a total of eight consecutive calls as follows:

18. N80°43'E 347.79 feet to an iron pin;
19. with the arc of a curve to right 123.02 feet to an iron pin, said curve having a radius of 325.0 feet and a chord of S88°26'E 122.29 feet;
20. S77°35'E 114.28 feet to an iron pin;
21. S83°48'E 30.16 feet to an iron pin;
22. with the arc of a curve to the left 111.00 feet to an iron pin, said curve having a radius of 350.0 feet and a chord of N87°07'E 110.54 feet to an iron pin;
23. N78°02'E 67.93 feet to an iron pin;

24. N58°05'E 105.99 feet to an iron pin;
25. N56°23'E 133.11 feet to an iron pin;

thence, continuing with a line severing remaining property of the University of Tennessee, a total of two consecutive calls, as follows:

26. N56°23'E 147.76 feet to an iron pin near the banks of Fort Loudoun Lake;
27. N56°23'E approximately 70 feet to a point on the 808 contour on the southern shoreline of Fort Loudoun Lake;

thence, southeasterly with the meanders of the 808 contour along the southern shoreline of Fort Loudoun Lake approximately 1120 feet to a point, said meander line having a chord of S59°38'E 1085.66 feet; thence, with property of Cherokee Bluff Co-owners Council, Inc., a total of five consecutive calls as follows:

28. S1°39'W approximately 50 feet to an iron pin near the banks of Fort Loudoun Lake;
29. S1°39'W 174.27 feet to a concrete monument, said monument having Tennessee Lambert Grid Co-ordinates N591,380.9 E 2,578,738.3;
30. S18°20'W 24.92 feet to an iron pin;
31. with the eastern boundary of Tract 5 further described herein S18°20'W 162.78 feet to an iron pin;
32. S18°20'W 1283.28 feet to a concrete right of way monument;

thence, with the northeastern right of way line of Cherokee Trail, a total of two consecutive calls as follows:

33. N32°13'W 166.80 feet to a concrete right of way monument;
34. N47°03'W 350.58 feet to the point of beginning;

and containing 72.50 acres after excluding Tracts 3,4,5,6, and 7 as further described herein.

TRACT 2

Beginning at a concrete right of way monument in the eastern right of way line of Alcoa Highway (U.S. 129), said monument having Tennessee Lambert Grid Co-ordinates N590,687.3, E2,575,777.5; thence, from said point of beginning with the eastern right of way line of Alcoa Highway, a total of four consecutive calls as follows:

35. N9°22'W 370.38 feet to a concrete right of way monument;
36. N9°22'W 391.31 feet to an iron pin;
37. S82°53'W 10.0 feet to an iron pin;
38. N7°00'W 107.37 feet to an iron pin;

thence, severing remaining property of the University of Tennessee, generally following the east, then south edge of an existing driveway, a total of twelve consecutive calls as follows:

39. with the arc of a curve to the left 108.79 feet to an iron pin, said curve having a radius of 75.0 feet and a chord of N34°34'E 99.50 feet;
40. N7°00'W 78.11 feet to an iron pin;
41. with the arc of a curve to the right 42.46 feet to an iron pin, said curve having a radius of 25.0 feet and a chord of N41°40'E 37.54 feet;
42. S89°41'E 158.31 feet to an iron pin;
43. S88°36'E 327.55 feet to an iron pin;
44. S87°00'E 60.50 feet to an iron pin;
45. N84°45'E 52.73 feet to an iron pin;
46. N86°24'E 135.52 feet to an iron pin;
47. with the arc of a curve to the left 41.80 feet to an iron pin, said curve having a radius of 35.0 feet and a chord of N52°11'E 39.36 feet;
48. N17°58'E 48.05 feet to an iron pin;
49. with the arc of a curve to the right 60.24 feet to an iron pin, said curve having a radius of 55.0 feet and a chord of N49°21'E 57.27 feet;
50. N80°43'E 117.73 feet to an iron pin;

thence, continuing with a line which is the common boundary of property of the University of Tennessee previously described herein as Tract 1, a total of two consecutive calls as follows:

51. S30°33'W 1177.52 feet to an iron pin;
52. S8°52'E 310.00 feet to an iron pin;

thence, with the right of way of Alcoa Highway four consecutive calls as follows:

53. N82°25'W 16.95 feet to an iron pin;

54. S34°04'W 130.0 feet to an iron pin;
55. N85°02'W 142.85 feet to an iron pin;
56. N18°40'W 254.95 feet to the point of beginning;

and containing approximately 15.215 acres.

TRACT 3

To reach the point of beginning commence at above defined point 'A'; thence, N17°00'E 48.15 feet to an iron pin; thence, N2°19'W 311.20 feet to an iron pin which is the point of beginning; thence from said point of beginning with the common boundary of Tract 4 as further described herein S87°55'W 287.50 feet to an iron pin; thence, severing Tract 1 as previously described herein, a total of six consecutive calls as follows:

57. N1°21'W 300.03 feet to an iron pin;
58. N87°55'E 262.30 feet to an iron pin;
59. S10°49'E 49.40 feet to an iron pin;
60. S8°49'E 60.0 feet to an iron pin;
61. S5°49'E 98.0 feet to an iron pin;
62. S2°22'E 93.80 feet to the point of beginning;

and containing approximately 1.924 acres.

TRACT 4

To reach the point of beginning commence at above defined Point 'A'; thence, N17°00'E 48.15 feet to an iron pin; thence, N2°19'W 311.20 feet to an iron pin which is the point of beginning; thence, from said point of beginning severing Tract 1 as previously described herein, a total of four consecutive calls as follows:

63. S2°19'E 311.20 feet to an iron pin;
64. S87°55'W 403.36 feet to an iron pin;
65. N2°05'W 311.20 feet to an iron pin;
66. N87°55'E 114.59 feet to an iron pin;

thence, with the common boundary of Tract 3 as previously described herein N87°55'E 287.50 feet to the point of beginning; and containing approximately 2.877 acres.

TRACT 5

To reach the point of beginning, commence at a concrete monument in the common boundary between Cherokee Bluff Co-Owners Council, Inc., and Tract 1 as previously described herein, said monument having Tennessee Lambert Grid Co-ordinates N591,380.9 E2,578,738.3; thence, S18°20'W 24.92 feet to an iron pin which is the point of beginning; thence, from said point of beginning with the boundary of Cherokee Bluff Co-Owners Council, Inc., S18°20'W 162.78 feet to an iron pin; thence, severing Tract 1 as previously described herein, a total of nine consecutive calls, as follows:

67. N69°35'W 83.06 feet to an iron pin;
68. S87°28'W 208.67 feet to an iron pin;
69. N41°06'W 13.32 feet to an iron pin;
70. N89°43'W 8.29 feet to an iron pin;
71. N2°06'W 89.21 feet to an iron pin;
72. N85°12'E 200.78 feet to an iron pin;
73. N7°30'E 39.34 feet to an iron pin;
74. N72°29'E 10.12 feet to an iron pin;
75. S80°45'E 144.83 feet to the point of beginning;

and containing approximately 0.938 acres.

TRACT 6

To reach the point of beginning, commence at a concrete monument in the common boundary between Cherokee Bluff Co-owners Council, Inc. and Tract 1 as previously described herein, said monument having Tennessee Lambert Grid Co-ordinates N591,380.9, E2,578,738.3; thence, N59°55'W 483.96 feet to an iron pin, which is the point of beginning; thence, from said point of beginning severing Tract 1 as previously described herein, a total of ten consecutive calls, as follows:

76. S87°47'W 272.53 feet to an iron pin;
77. N30°10'W 34.12 feet to an iron pin;
78. N54°12'E 40.29 feet to an iron pin;
79. N58°54'E 18.66 feet to an iron pin;
80. N58°23'E 29.87 feet to an iron pin;
81. N10°03'E 26.31 feet to an iron pin;
82. N53°50'E 47.61 feet to an iron pin, said pin being defined as Point `B' for further reference herein;
83. N89°34'E 121.56 feet to an iron pin;
84. S35°51'E 81.49 feet to an iron pin;
85. S3°06'E 56.75 feet to the point of beginning;

and containing approximately 0.652 acres.

TRACT 7

To reach the point of beginning, commence at above referenced Point `B'; thence, N58°24'W 159.32 feet to an iron pin which is the point of beginning; thence, from said point of beginning, severing Tract 1 as previously described herein four consecutive calls, as follows:

86. S56°09'W 168.19 feet to a P.K. nail;
87. N28°45'W 114.02 feet to a P.K. nail;
88. N61°16'E 167.29 feet to an iron pin;
89. S28°53'E 99.02 feet to the point of beginning;

and containing approximately 0.409 acres.

All of the above described Tracts 1 through 7 being a portion of the same property conveyed to the State of Tennessee as Trustee for the use and benefit of the University of Tennessee by deeds from Knox County, Tennessee dated January 26, 1916 and July 22, 1942 recorded at Deed Book 285, page 397 and Deed Book 645, page 180, respectively, Register's Office for Knox County, Tennessee.

ACCESS EASEMENT TO TRACT 3

To reach the point of beginning commence at above referenced Point `A'; thence, N87°26'E 15.93 feet along the north right of way line which terminates Old Cherokee Trail right of way to a point which is the point of beginning; thence, severing Tract 1, previously described herein N2°19'W 45.37 feet to an iron pin; thence with the eastern boundary of Tract 4 previously described herein N2°19'W 311.20 feet to an iron pin; thence, with the eastern boundary of Tract 3 previously described herein N2°22'W 93.80 feet to an iron pin; thence, two consecutive calls severing Lot 1 previously described herein, as follows:

90. N87°38'E 40.0 feet to a point;
91. S2°22'E 93.81 feet to a point;
92. S2°19'E 356.42 feet to a point;

thence, S87°26'W 40.0 feet with the north right of way line which terminates Old Cherokee Trail right of way to the point of beginning.

State of Tennessee Payment Center

Confirmation of Payment

Almost finished...

Your payment has been accepted.
However, your total transaction **WILL NOT** be complete until you click "Continue" below.

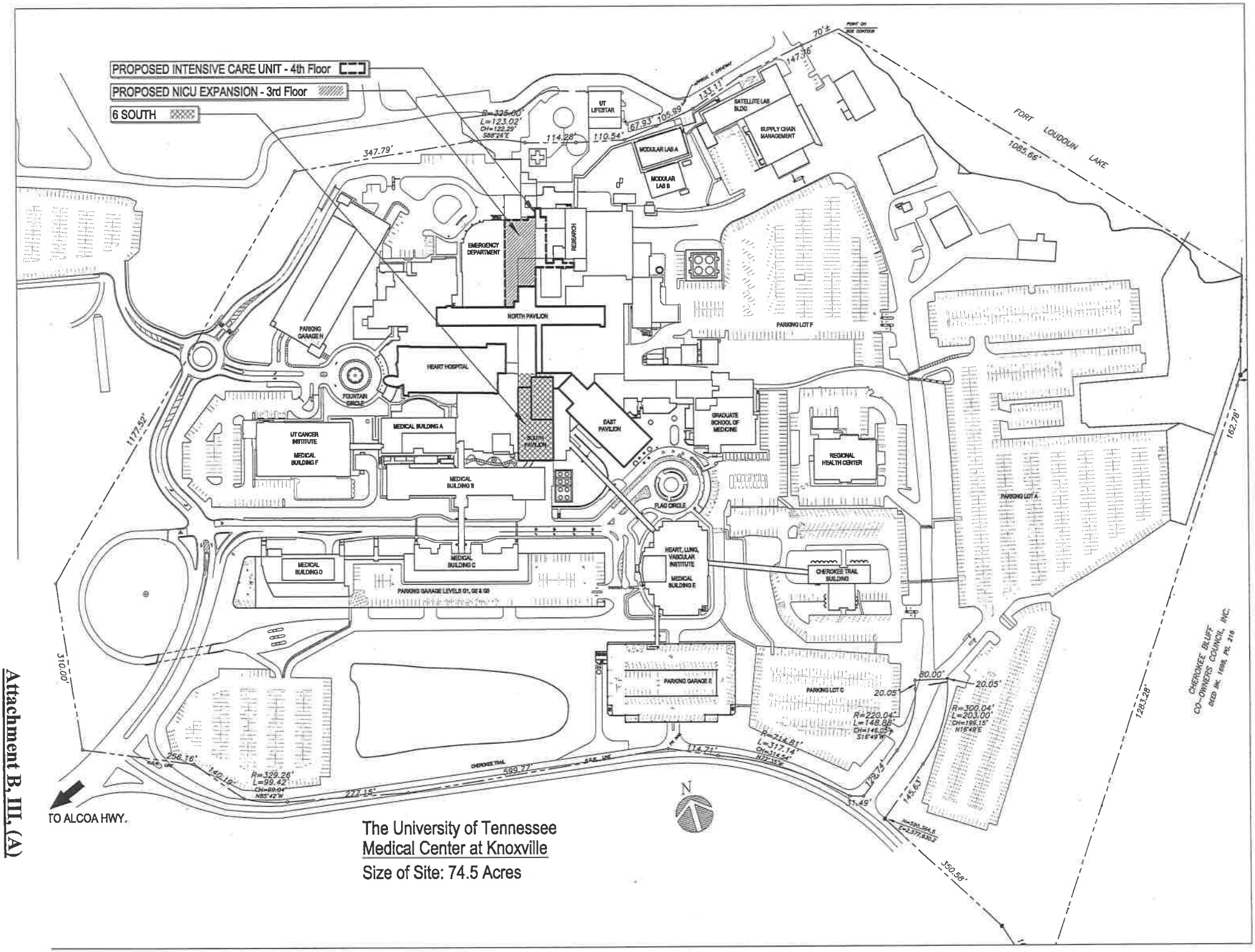
For Your Records

Your confirmation number is: 157951471

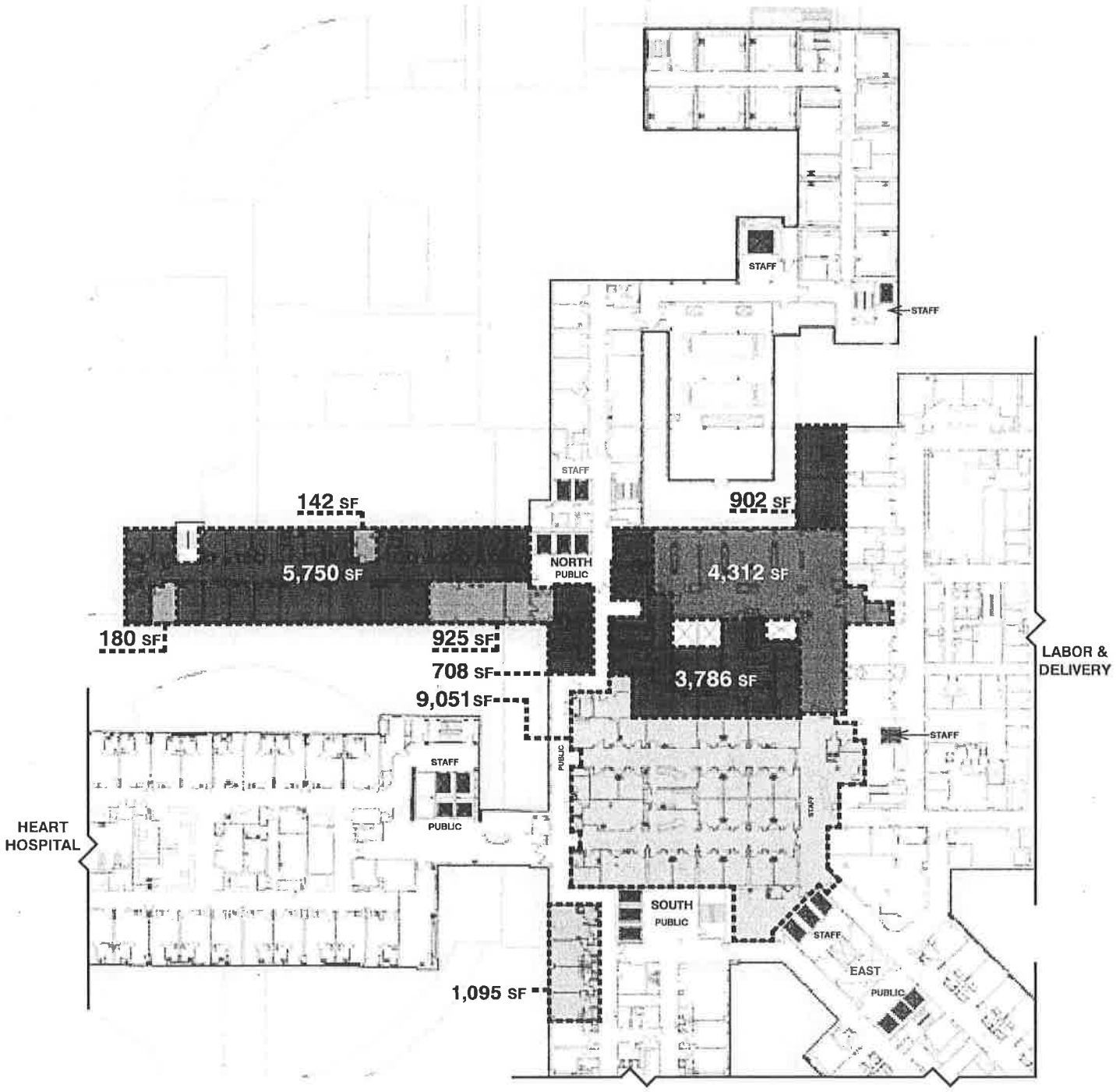
Name/ID: UCC11 Information Request

Date/Time: Tuesday, August 26, 2014 (9:25 am CDT)

Payment Amount: $17.25



Attachment B, III, (A)



EXISTING ROOMING-IN
INFANT AREA
SUPPORT
RELOCATABLE (NON-NICU)
EXISTING NICU PHASE I

04SEP2014

3RD FLOOR PLAN - EXISTING NICU

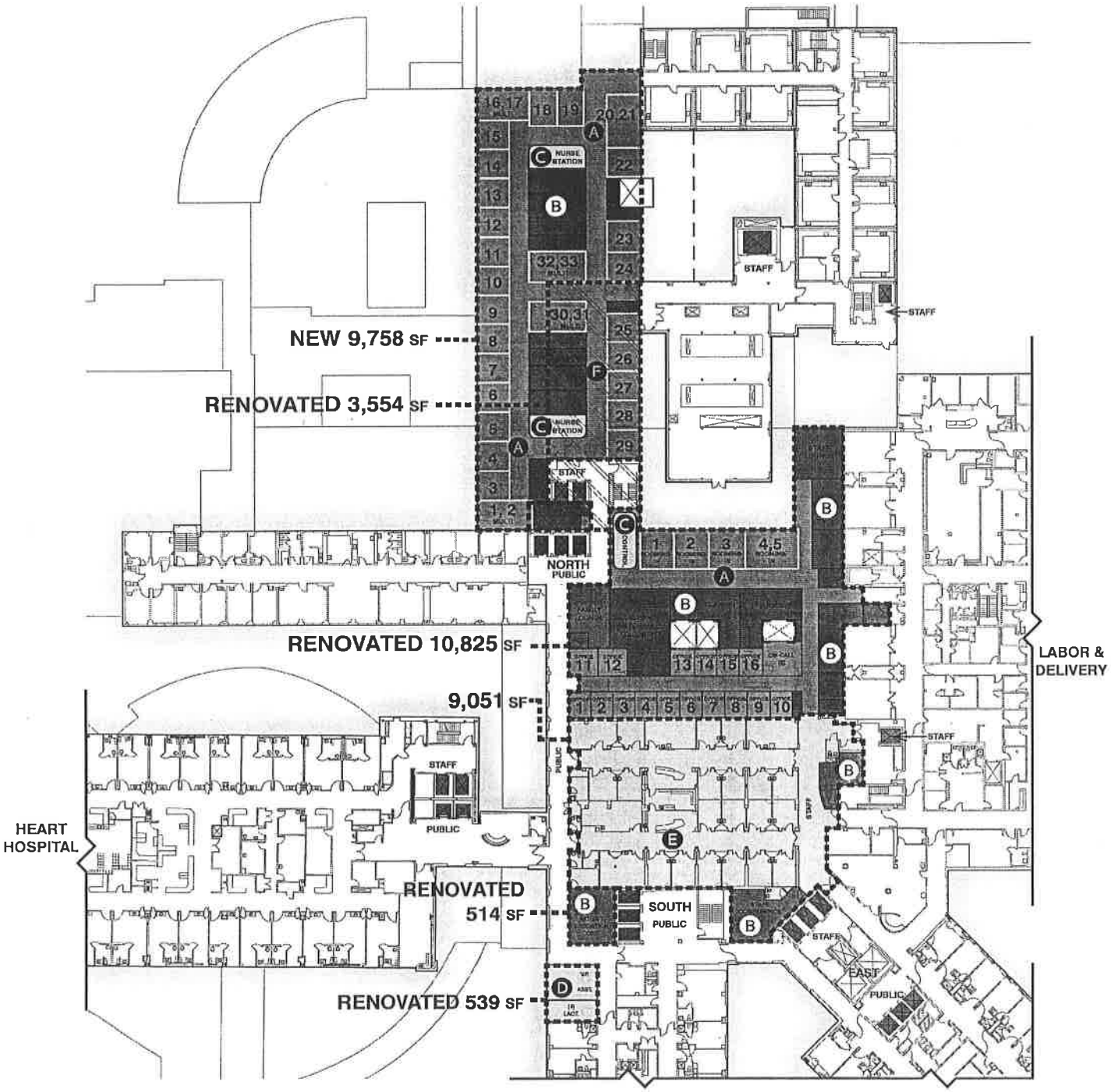
UT MEDICAL CENTER - 3RD & 4TH FLOOR EXPANSION
UNIVERSITY HEALTH SYSTEM

0

BARBERMcMURRY

132000

Attachment B, IV



08SEP2014

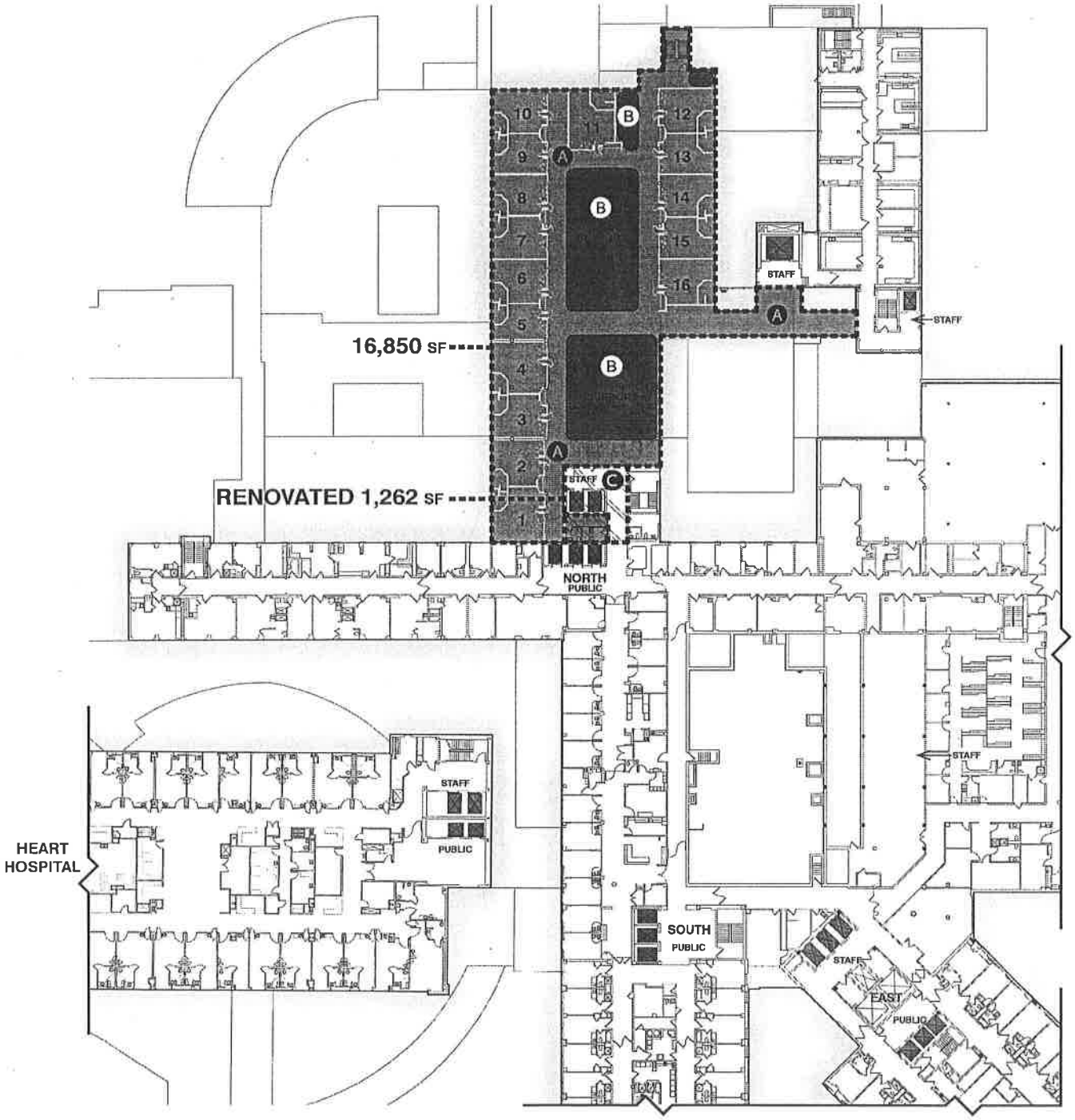
3 3RD FLOOR PLAN - NICU PHASE II

UT MEDICAL CENTER - 3RD & 4TH FLOOR EXPANSION
UNIVERSITY HEALTH SYSTEM

0 16 32 64

BARBERMcMURRY architects since 1915

132000



08SEP2014

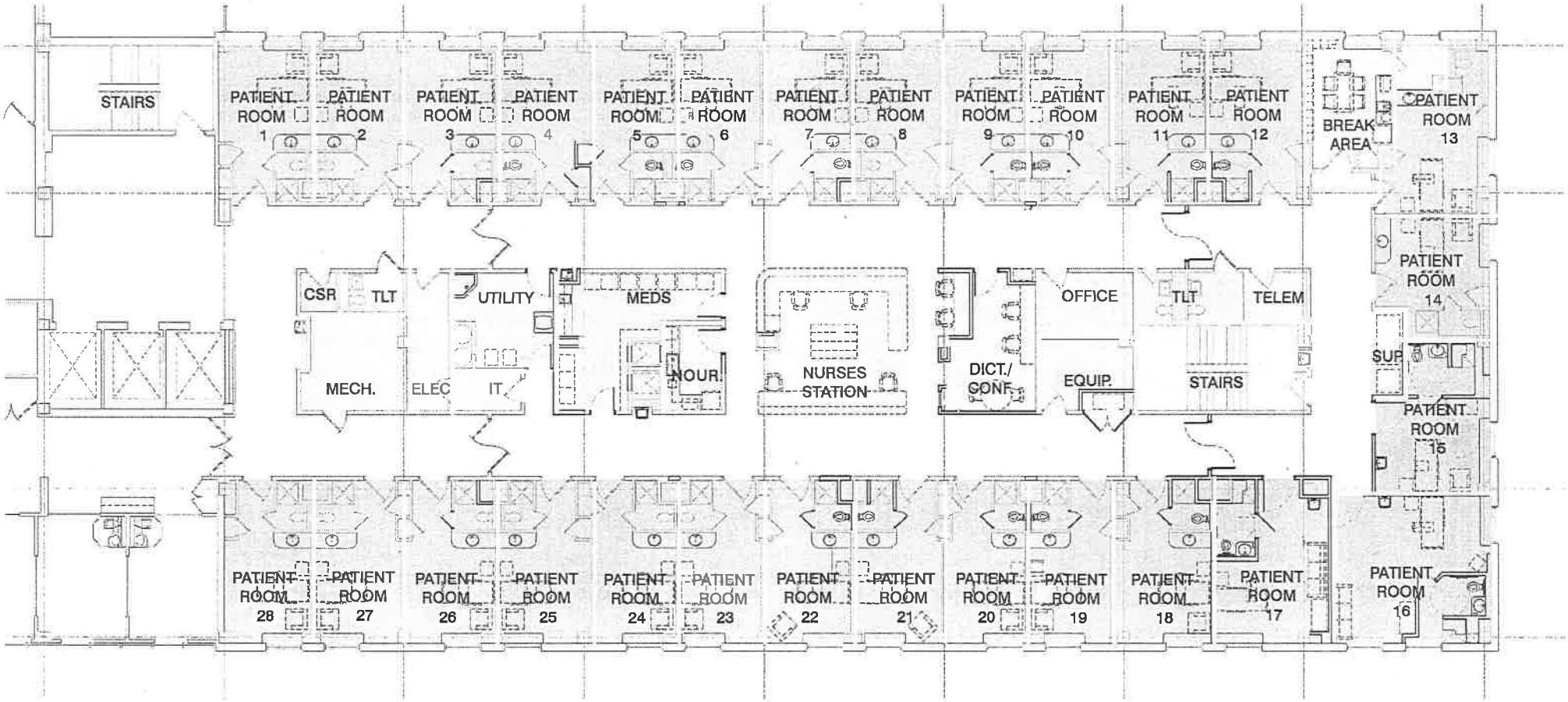
4 4TH FLOOR PLAN - INTENSIVE CARE UNIT

UT MEDICAL CENTER - 3RD & 4TH FLOOR EXPANSION
UNIVERSITY HEALTH SYSTEM

0 16 32 64

BARBERMcMURRY architects since 1915

132000



TOTAL PATIENT ROOMS: 28

PATIENT ROOMS 15,16, AND 17 ARE ALLOCATED WHEELCHAIR ACCESSIBLE

10SEP2014

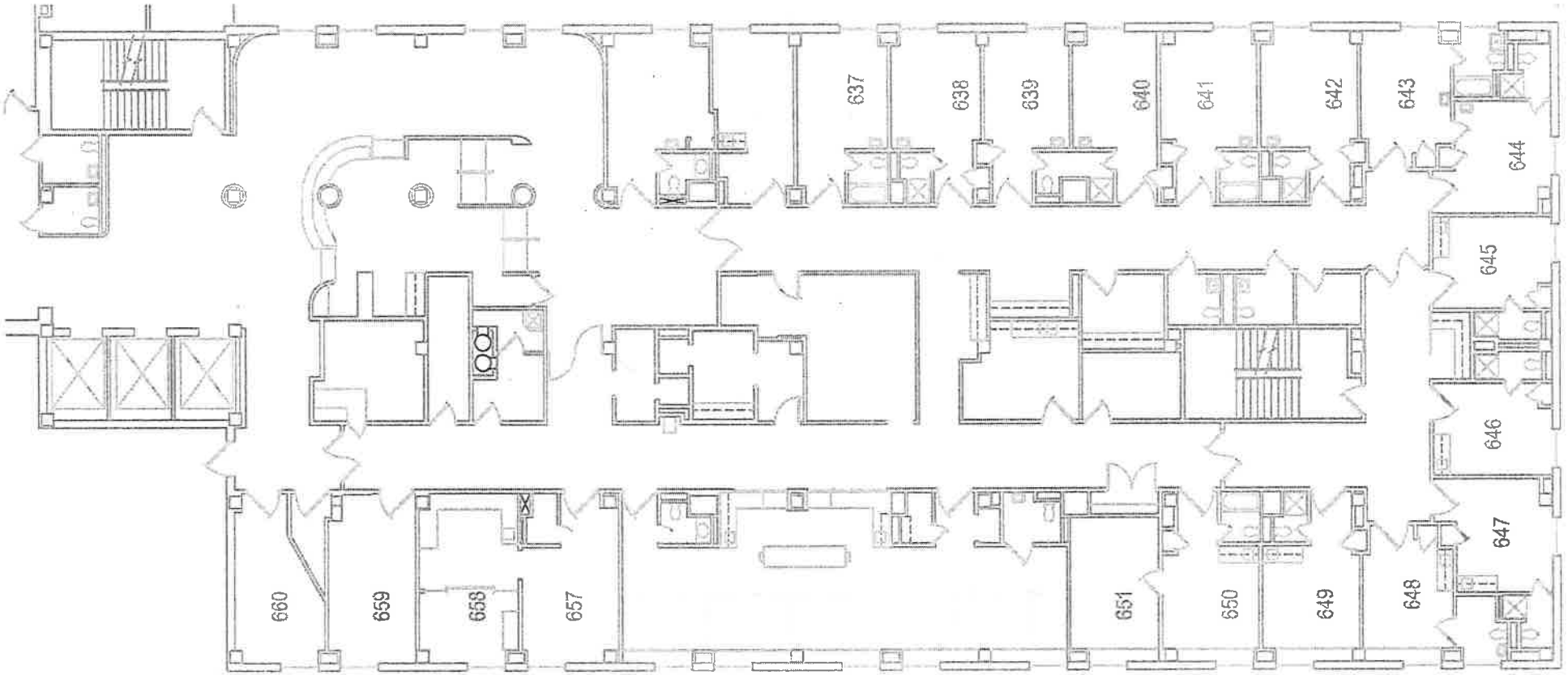
6 SOUTH PROPOSED

UT MEDICAL CENTER
UNIVERSITY HEALTH SYSTEMS

0 8 16 32

BARBERMcMURRY
architects since 1915

144200



10SEP2014

6 SOUTH EXISTING OUTPATIENT CLINIC

UT MEDICAL CENTER
UNIVERSITY HEALTH SYSTEMS

0 8 16 32

BARBERMcMURRY
architects since 1915

144200

AWARDS	Agency	Date
ACTION Registry - GWTG Platinum Performance	NCDR (National Cardiovascular Data Registry)	2013
Beacon Award for Excellence MCC - Silver	American Association of Critical-Care Nurses	2013-2016
2013 Beacon Award for Excellence	American Association of Critical Care Nurses	2013
Best in Region, Surgical Cardiac Services	Healthgrades	
Best Hospitals National (top 50) Gynecology &	US News & World Report	2012-2013
Best Regional Hospitals - Cancer, Cardiology & Heart	US News & World Report	2012-2013
Best Regional Hospital - Orthopaedics	US News & World Report	2014
Breast Imaging Center of Excellence	American College of Radiology	
Certificate of Distinction for Advanced Certification as	Joint Commission	
Advanced Certification as a Comprehensive Stroke Center	Joint Commission	2013
Consumer Choice Award	National Research Corp.	2001-2013
Excellence in Quality Reporting	Care Science	2006
Exemplar Hospital - ProjectJOINTS - University Joint	Institute for Healthcare Improvement (IHI)	Sep-11
Fit Friendly Gold Worksite Wellness	American Heart Association	2010-2014
Get with the Guidelines Heart Failure Gold	American Heart Association	2011
Get with the Guidelines Heart Failure Gold Plus	American Heart Association	2012-2013
Get with the Guidelines Heart Failure Silver	American Heart Association	2010
Get with the Guidelines Heart Failure -High Level of	American Heart Association	2010
Get with the Guidelines Stroke Bronze	American Heart Association/American Stroke Assoc.	2008
Get with the Guidelines Stroke Gold	American Heart Association/American Stroke Assoc.	2010
Get with the Guidelines Stroke Gold Plus	American Heart Association/American Stroke Assoc.	2011-2012
Get with the Guidelines Stroke Gold Plus and Target Stroke	American Heart Association/American Stroke Assoc.	2013
Get with the Guidelines Stroke Gold Plus and Target Strokes	American Heart Association/American Stroke Assoc.	2014
Get with the Guidelines Stroke Silver	American Heart Association/American Stroke Assoc.	2009
Magnet Designation	American Nurses Credentialing Center	2011 - 2015
Outstanding Patient Experience Award	Healthgrades	2012-2013
STEMI	American Heart Association	
THA Health Information N Data	Blue Cross Blue Shield	2014
TNCPE Achievement Award - Level 3	TNCPE	2012

ACUTE-CARE BED NEED PROJECTIONS FOR 2014 AND 2018, BASED ON FINAL 2012 HOSPITAL JARS

COUNTY	2012		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2012 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2012	2014	2018	ADC-2014	NEED 2014	ADC-2018	NEED 2018	LICENSED	STAFFED	LICENSED	STAFFED
Anderson	47,731	131	164	94,639	95,470	97,048	132	165	134	168	301	255	-133	-87
Blount	51,235	140	176	97,454	99,770	104,941	144	180	151	189	304	238	-115	-49
Campbell	18,681	51	68	21,557	21,827	22,326	52	69	53	70	120	97	-50	-27
Claiborne	7,878	22	32	12,643	12,753	13,009	22	33	22	33	85	39	-52	-6
Cocke	7,541	21	31	16,066	16,425	17,225	21	32	22	33	74	36	-41	-3
Cumberland	21,801	60	78	45,561	46,213	48,038	61	79	63	81	189	123	-108	-42
Fentress	0	0	0	.	.	.	.	.	.	.	85	54	.	.
Grainger	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Hamblen	39,464	108	135	76,894	77,909	80,095	110	137	113	141	302	212	-161	-71
Hancock	1,229	3	8	1,661	1,655	1,652	3	8	3	8	10	10	-2	-2
Hawkins	3,542	10	17	10,354	10,441	10,555	10	17	10	17	50	46	-33	-29
Jefferson	8,533	23	35	17,351	17,752	18,648	24	35	25	37	58	58	-21	-21
Knox	442,861	1,213	1,517	781,145	797,585	831,502	1,239	1,549	1,292	1,614	1,877	1,777	-263	-163
Loudon	6,123	17	26	12,093	12,365	12,912	17	27	18	28	50	30	-22	-2
McMinn	15,973	44	59	32,166	32,503	33,184	44	60	45	61	190	111	-129	-50
Monroe	10,213	28	40	18,562	18,905	19,665	29	41	30	42	59	59	-17	-17
Morgan	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Roane	6,593	18	28	13,068	13,113	13,243	18	28	18	28	105	36	-77	-8
Scott	.	.	.	.	.	.	.	.	.	.	.	..	.	.
Sevier	13,019	36	50	37,258	38,189	40,405	37	51	39	53	79	69	-26	-16
Union	.													
Total	702,417	1,925	2,464	1,288,472	1,312,875	1,267,400	1,963	2,511	2,038	2,603	3,853	3,196	-1,250	-593

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. 11/14/2013

ata from Final JAR-Hospitals Schedules F and G. Underlying Tennessee population estimates and projections (2013 Series) from Office of Health Statistics. Projections and estimates for other states obtained from those states.

Attachment C, I, Need,1, (1)

ACUTE-CARE BED NEED PROJECTIONS FOR 2014 AND 2018, BASED ON FINAL 2012 HOSPITAL JARS

COUNTY	2012		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2012 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2012	2014	2018	ADC-2014	NEED 2014	ADC-2018	NEED 2018	LICENSED	STAFFED	LICENSED	STAFFED
Anderson	47,731	131	164	94,639	95,470	97,048	132	165	134	168	301	255	-133	-87
Beford	7,281	20	30	17,853	18,323	19,505	20	31	22	33	60	60	-27	-27
Benton	1,959	5	11	2,278	2,264	2,243	5	11	5	11	25	12	-14	-1
Bledsoe	2,984	8	15	2,088	2,078	2,085	8	15	8	15	25	25	-10	-10
Blount	51,235	140	176	97,454	99,770	104,941	144	180	151	189	304	238	-115	-49
Bradley	38,232	105	131	82,623	84,112	87,052	107	133	110	138	351	207	-213	-69
Campbell	18,681	51	68	21,557	21,827	22,326	52	69	53	70	120	97	-50	-27
Cannon	6,638	18	28	3,813	3,874	3,969	18	29	19	29	60	50	-31	-21
Carroll	6,718	18	28	14,137	14,118	14,111	18	28	18	28	115	68	-87	-40
Carter	15,622	43	58	29,978	30,095	30,448	43	58	43	59	121	79	-62	-20
Cheatham	1,549	4	9	1,364	1,381	1,413	4	9	4	9	12	12	-3	-3
Chester	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Claiborne	7,878	22	32	12,643	12,753	13,009	22	33	22	33	85	39	-52	-6
Clay	5,592	15	24	5,364	5,343	5,345	15	24	15	24	36	34	-12	-10
Cocke	7,541	21	31	16,066	16,425	17,225	21	32	22	33	74	36	-41	-3
Coffee	31,305	86	107	56,704	57,545	59,957	87	109	91	113	214	159	-101	-46
Crockett	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Cumberland	21,801	60	78	45,561	46,213	48,038	61	79	63	81	189	123	-108	-42
Davidson	763,385	2,092	2,614	1,451,264	1,488,518	1,562,068	2,145	2,681	2,251	2,814	3,754	3,129	-940	-315
Decatur	3,411	9	16	5,011	5,052	5,157	9	17	10	17	40	27	-23	-10
DeKalb	4,110	11	19	7,665	7,707	7,805	11	19	12	19	71	56	-52	-37
Dickson	18,017	49	66	33,604	33,850	34,413	50	66	51	67	157	120	-90	-53
Dyer	12,937	35	49	33,319	33,224	33,183	35	49	35	49	225	120	-176	-71
Fayette	714	2	5	2,325	2,406	2,603	2	5	2	6	46	10	-40	-4
Fentress	0	0	0	.	.	.	.	.	.	.	85	54	.	.
Franklin	22,404	61	80	33,182	33,338	33,983	62	80	63	81	152	110	-71	-29
Gibson	5,069	14	23	7,947	8,051	8,206	14	23	14	23	209	90	-186	-67
Giles	9,124	25	37	12,333	12,327	12,331	25	37	25	37	95	81	-58	-44
Grainger	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Greene	27,601	76	96	50,076	50,565	51,689	76	97	78	99	240	170	-141	-71
Grundy	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Hamblen	39,464	108	135	76,894	77,909	80,095	110	137	113	141	302	212	-161	-71
Hamilton	392,786	1,076	1,345	696,028	710,184	736,123	1,098	1,372	1,138	1,423	1,551	1,235	-128	188
Hancock	1,229	3	8	1,661	1,655	1,652	3	8	3	8	10	10	-2	-2
Hardeman	815	2	6	2,537	2,508	2,480	2	6	2	6	51	23	-45	-17
Hardin	7,103	20	30	14,725	14,795	14,963	20	30	20	30	58	49	-28	-19
Hawkins	3,542	10	17	10,354	10,441	10,555	10	17	10	17	50	46	-33	-29
Haywood	1,617	4	9	3,872	3,831	3,811	4	9	4	9	62	36	-53	-27
Henderson	2,444	7	13	6,143	6,182	6,284	7	13	7	13	45	45	-32	-32
Henry	16,775	46	62	28,422	28,546	28,712	46	62	46	62	142	101	-80	-39
Hickman	492	1	4	1,425	1,427	1,444	1	4	1	4	15	15	-11	-11
Houston	2,870	8	14	4,017	4,052	4,109	8	15	8	15	25	25	-10	-10
Humphreys	1,697	5	10	3,463	3,466	3,477	5	10	5	10	25	25	-15	-15

ACUTE-CARE BED NEED PROJECTIONS FOR 2014 AND 2018, BASED ON FINAL 2012 HOSPITAL JARS

COUNTY	2012		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2012 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2012	2014	2018	ADC-2014	NEED 2014	ADC-2018	NEED 2018	LICENSED	STAFFED	LICENSED	STAFFED
Jackson	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Jefferson	8,533	23	35	17,351	17,752	18,648	24	35	25	37	58	58	-21	-21
Johnson	51	0	1	233	232	232	0	1	0	1	2	2	-1	-1
Knox	442,861	1,213	1,517	781,145	797,585	831,502	1,239	1,549	1,292	1,614	1,877	1,777	-263	-163
Lake	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Lauderdale	3,044	8	15	4,293	4,252	4,218	8	15	8	15	25	25	-10	-10
Lawrence	9,298	26	37	18,503	18,540	18,545	26	37	26	37	99	80	-62	-43
Lewis	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Lincoln	7,435	20	31	17,852	18,159	18,898	21	31	22	32	59	59	-27	-27
Loudon	6,123	17	26	12,093	12,365	12,912	17	27	18	28	50	30	-22	-2
McMinn	15,973	44	59	32,166	32,503	33,184	44	60	45	61	190	111	-129	-50
McNairy	4,953	14	22	11,089	11,200	11,451	14	22	14	23	45	45	-22	-22
Macon	3,793	10	18	5,934	6,057	6,301	11	18	11	19	25	25	-6	-6
Madison	179,979	493	616	281,828	283,339	286,657	496	620	502	627	787	729	-160	-102
Marion	14,492	40	54	9,647	9,762	9,980	40	55	41	56	70	63	-14	-7
Marshall	675	2	5	1,895	1,911	1,956	2	5	2	5	25	12	-20	-7
Maury	42,096	115	144	102,509	102,974	104,036	116	145	117	146	255	215	-109	-69
Meigs	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Monroe	10,213	28	40	18,562	18,905	19,665	29	41	30	42	59	59	-17	-17
Montgomery	43,692	120	150	126,007	130,796	139,341	124	155	132	165	270	220	-105	-55
Moore	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Morgan	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Obion	10,628	29	42	20,715	20,637	20,560	29	42	29	41	173	85	-132	-44
Overton	16,555	45	61	21,794	22,030	22,558	46	62	47	63	114	82	-51	-19
Perry	6,000	16	26	5,114	5,146	5,192	17	26	17	26	53	25	-27	1
Pickett	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Polk	0	0	0	.	.	.	.	.	.	.	25	25	.	.
Putnam	61,949	170	212	105,866	108,424	113,926	174	217	183	228	247	243	-19	-15
Rhea	3,533	10	17	7,701	7,893	8,211	10	17	10	18	25	25	-7	-7
Roane	6,593	18	28	13,068	13,113	13,243	18	28	18	28	105	36	-77	-8
Robertson	16,379	45	61	28,555	29,416	31,016	46	62	49	65	109	66	-44	-1
Rutherford	80,182	220	275	229,262	241,520	267,897	231	289	257	321	387	369	-66	-48
Scott	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Sequatchie	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Sevier	13,019	36	50	37,258	38,189	40,405	37	51	39	53	79	69	-26	-16
Shelby	934,049	2,559	3,199	1,416,974	1,430,639	1,457,026	2,584	3,230	2,631	3,289	4,177	3,115	-888	174
Smith	10,604	29	42	13,707	13,945	14,448	30	42	31	44	98	85	-54	-41
Stewart	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Sullivan	242,753	665	831	417,761	423,735	435,560	675	843	693	867	1,056	769	-189	98
Sumner	48,799	134	167	115,476	119,215	126,486	138	173	146	183	303	213	-120	-30
Tipton	4,341	12	20	12,974	13,252	13,875	12	20	13	21	100	44	-79	-23
Trousdale	1,678	5	10	2,060	2,117	2,220	5	10	5	10	25	21	-15	-11
Unicoi	4,283	12	20	6,172	6,198	6,244	12	20	12	20	48	7	-28	13

ACUTE-CARE BED NEED PROJECTIONS FOR 2014 AND 2018, BASED ON FINAL 2012 HOSPITAL JARS

COUNTY	2012		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2012 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2012	2014	2018	ADC-2014	NEED 2014	ADC-2018	NEED 2018	LICENSED	STAFFED	LICENSED	STAFFED
Union	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Van Buren	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Warren	11,619	32	45	21,743	21,931	22,287	32	45	33	46	125	48	-79	-2
Washington	167,908	460	575	202,955	206,820	214,435	469	586	486	608	581	581	27	27
Wayne	1,990	6	11	4,701	4,683	4,647	5	11	5	11	80	32	-69	-21
Weakley	6,398	18	27	17,299	17,478	17,808	18	27	18	28	100	65	-72	-37
White	7,122	20	30	10,543	10,722	11,141	20	30	21	31	60	44	-29	-13
Williamson	31,464	86	108	99,271	103,289	111,805	90	112	97	121	185	185	-64	-64
Wilson	34,781	95	119	56,265	58,335	62,267	99	124	105	132	245	245	-113	-113

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. 11/14/2013

Data from Final JAR-Hospitals Schedules F and G. Underlying Tennessee population estimates and projections (2013 Series) from Office of Health Statistics. Projections and estimates for other states obtained from those states.

ACUTE-CARE BED NEED PROJECTIONS FOR 2014 AND 2018, BASED ON FINAL 2012 HOSPITAL JARS

COUNTY	2012		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2012 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2012	2014	2018	ADC-2014	NEED 2014	ADC-2018	NEED 2018	LICENSED	STAFFED	LICENSED	STAFFED
Anderson	47,731	131	164	94,639	95,470	97,048	132	165	134	168	301	255	-133	-87
Beford	7,281	20	30	17,853	18,323	19,505	20	31	22	33	60	60	-27	-27
Benton	1,959	5	11	2,278	2,264	2,243	5	11	5	11	25	12	-14	-1
Bledsoe	2,984	8	15	2,088	2,078	2,085	8	15	8	15	25	25	-10	-10
Blount	51,235	140	176	97,454	99,770	104,941	144	180	151	189	304	238	-115	-49
Bradley	38,232	105	131	82,623	84,112	87,052	107	133	110	138	351	207	-213	-69
Campbell	18,681	51	68	21,557	21,827	22,326	52	69	53	70	120	97	-50	-27
Cannon	6,638	18	28	3,813	3,874	3,969	18	29	19	29	60	50	-31	-21
Carroll	6,718	18	28	14,137	14,118	14,111	18	28	18	28	115	68	-87	-40
Carter	15,622	43	58	29,978	30,095	30,448	43	58	43	59	121	79	-62	-20
Cheatham	1,549	4	9	1,364	1,381	1,413	4	9	4	9	12	12	-3	-3
Chester	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Claiborne	7,878	22	32	12,643	12,753	13,009	22	33	22	33	85	39	-52	-6
Clay	5,592	15	24	5,364	5,343	5,345	15	24	15	24	36	34	-12	-10
Cocke	7,541	21	31	16,066	16,425	17,225	21	32	22	33	74	36	-41	-3
Coffee	31,305	86	107	56,704	57,545	59,957	87	109	91	113	214	159	-101	-46
Crockett	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Cumberland	21,801	60	78	45,561	46,213	48,038	61	79	63	81	189	123	-108	-42
Davidson	763,385	2,092	2,614	1,451,264	1,488,518	1,562,068	2,145	2,681	2,251	2,814	3,754	3,129	-940	-315
Decatur	3,411	9	16	5,011	5,052	5,157	9	17	10	17	40	27	-23	-10
DeKalb	4,110	11	19	7,665	7,707	7,805	11	19	12	19	71	56	-52	-37
Dickson	18,017	49	66	33,604	33,850	34,413	50	66	51	67	157	120	-90	-53
Dyer	12,937	35	49	33,319	33,224	33,183	35	49	35	49	225	120	-176	-71
Fayette	714	2	5	2,325	2,406	2,603	2	5	2	6	46	10	-40	-4
Fentress	0	0	0	.	.	.	.	.	.	.	85	54	.	.
Franklin	22,404	61	80	33,182	33,338	33,983	62	80	63	81	152	110	-71	-29
Gibson	5,069	14	23	7,947	8,051	8,206	14	23	14	23	209	90	-186	-67
Giles	9,124	25	37	12,333	12,327	12,331	25	37	25	37	95	81	-58	-44
Grainger	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Greene	27,601	76	96	50,076	50,565	51,689	76	97	78	99	240	170	-141	-71
Grundy	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Hamblen	39,464	108	135	76,894	77,909	80,095	110	137	113	141	302	212	-161	-71
Hamilton	392,786	1,076	1,345	696,028	710,184	736,123	1,098	1,372	1,138	1,423	1,551	1,235	-128	188
Hancock	1,229	3	8	1,661	1,655	1,652	3	8	3	8	10	10	-2	-2
Hardeman	815	2	6	2,537	2,508	2,480	2	6	2	6	51	23	-45	-17
Hardin	7,103	20	30	14,725	14,795	14,963	20	30	20	30	58	49	-28	-19
Hawkins	3,542	10	17	10,354	10,441	10,555	10	17	10	17	50	46	-33	-29
Haywood	1,617	4	9	3,872	3,831	3,811	4	9	4	9	62	36	-53	-27
Henderson	2,444	7	13	6,143	6,182	6,284	7	13	7	13	45	45	-32	-32
Henry	16,775	46	62	28,422	28,546	28,712	46	62	46	62	142	101	-80	-39
Hickman	492	1	4	1,425	1,427	1,444	1	4	1	4	15	15	-11	-11
Houston	2,870	8	14	4,017	4,052	4,109	8	15	8	15	25	25	-10	-10
Humphreys	1,697	5	10	3,463	3,466	3,477	5	10	5	10	25	25	-15	-15

ACUTE-CARE BED NEED PROJECTIONS FOR 2014 AND 2018, BASED ON FINAL 2012 HOSPITAL JARS

COUNTY	2012		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2012 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2012	2014	2018	ADC-2014	NEED 2014	ADC-2018	NEED 2018	LICENSED	STAFFED	LICENSED	STAFFED
Jackson	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Jefferson	8,533	23	35	17,351	17,752	18,648	24	35	25	37	58	58	-21	-21
Johnson	51	0	1	233	232	232	0	1	0	1	2	2	-1	-1
Knox	442,861	1,213	1,517	781,145	797,585	831,502	1,239	1,549	1,292	1,614	1,877	1,777	-263	-163
Lake	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Lauderdale	3,044	8	15	4,293	4,252	4,218	8	15	8	15	25	25	-10	-10
Lawrence	9,298	26	37	18,503	18,540	18,545	26	37	26	37	99	80	-62	-43
Lewis	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Lincoln	7,435	20	31	17,852	18,159	18,898	21	31	22	32	59	59	-27	-27
Loudon	6,123	17	26	12,093	12,365	12,912	17	27	18	28	50	30	-22	-2
McMinn	15,973	44	59	32,166	32,503	33,184	44	60	45	61	190	111	-129	-50
McNairy	4,953	14	22	11,089	11,200	11,451	14	22	14	23	45	45	-22	-22
Macon	3,793	10	18	5,934	6,057	6,301	11	18	11	19	25	25	-6	-6
Madison	179,979	493	616	281,828	283,339	286,657	496	620	502	627	787	729	-160	-102
Marion	14,492	40	54	9,647	9,762	9,980	40	55	41	56	70	63	-14	-7
Marshall	675	2	5	1,895	1,911	1,956	2	5	2	5	25	12	-20	-7
Maury	42,096	115	144	102,509	102,974	104,036	116	145	117	146	255	215	-109	-69
Meigs	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Monroe	10,213	28	40	18,562	18,905	19,665	29	41	30	42	59	59	-17	-17
Montgomery	43,692	120	150	126,007	130,796	139,341	124	155	132	165	270	220	-105	-55
Moore	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Morgan	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Obion	10,628	29	42	20,715	20,637	20,560	29	42	29	41	173	85	-132	-44
Overton	16,555	45	61	21,794	22,030	22,558	46	62	47	63	114	82	-51	-19
Perry	6,000	16	26	5,114	5,146	5,192	17	26	17	26	53	25	-27	1
Pickett	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Polk	0	0	0	.	.	.	.	.	.	.	25	25	.	.
Putnam	61,949	170	212	105,866	108,424	113,926	174	217	183	228	247	243	-19	-15
Rhea	3,533	10	17	7,701	7,893	8,211	10	17	10	18	25	25	-7	-7
Roane	6,593	18	28	13,068	13,113	13,243	18	28	18	28	105	36	-77	-8
Robertson	16,379	45	61	28,555	29,416	31,016	46	62	49	65	109	66	-44	-1
Rutherford	80,182	220	275	229,262	241,520	267,897	231	289	257	321	387	369	-66	-48
Scott	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Sequatchie	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Sevier	13,019	36	50	37,258	38,189	40,405	37	51	39	53	79	69	-26	-16
Shelby	934,049	2,559	3,199	1,416,974	1,430,639	1,457,026	2,584	3,230	2,631	3,289	4,177	3,115	-888	174
Smith	10,604	29	42	13,707	13,945	14,448	30	42	31	44	98	85	-54	-41
Stewart	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Sullivan	242,753	665	831	417,761	423,735	435,560	675	843	693	867	1,056	769	-189	98
Sumner	48,799	134	167	115,476	119,215	126,486	138	173	146	183	303	213	-120	-30
Tipton	4,341	12	20	12,974	13,252	13,875	12	20	13	21	100	44	-79	-23
Trousdale	1,678	5	10	2,060	2,117	2,220	5	10	5	10	25	21	-15	-11
Unicoi	4,283	12	20	6,172	6,198	6,244	12	20	12	20	48	7	-28	13

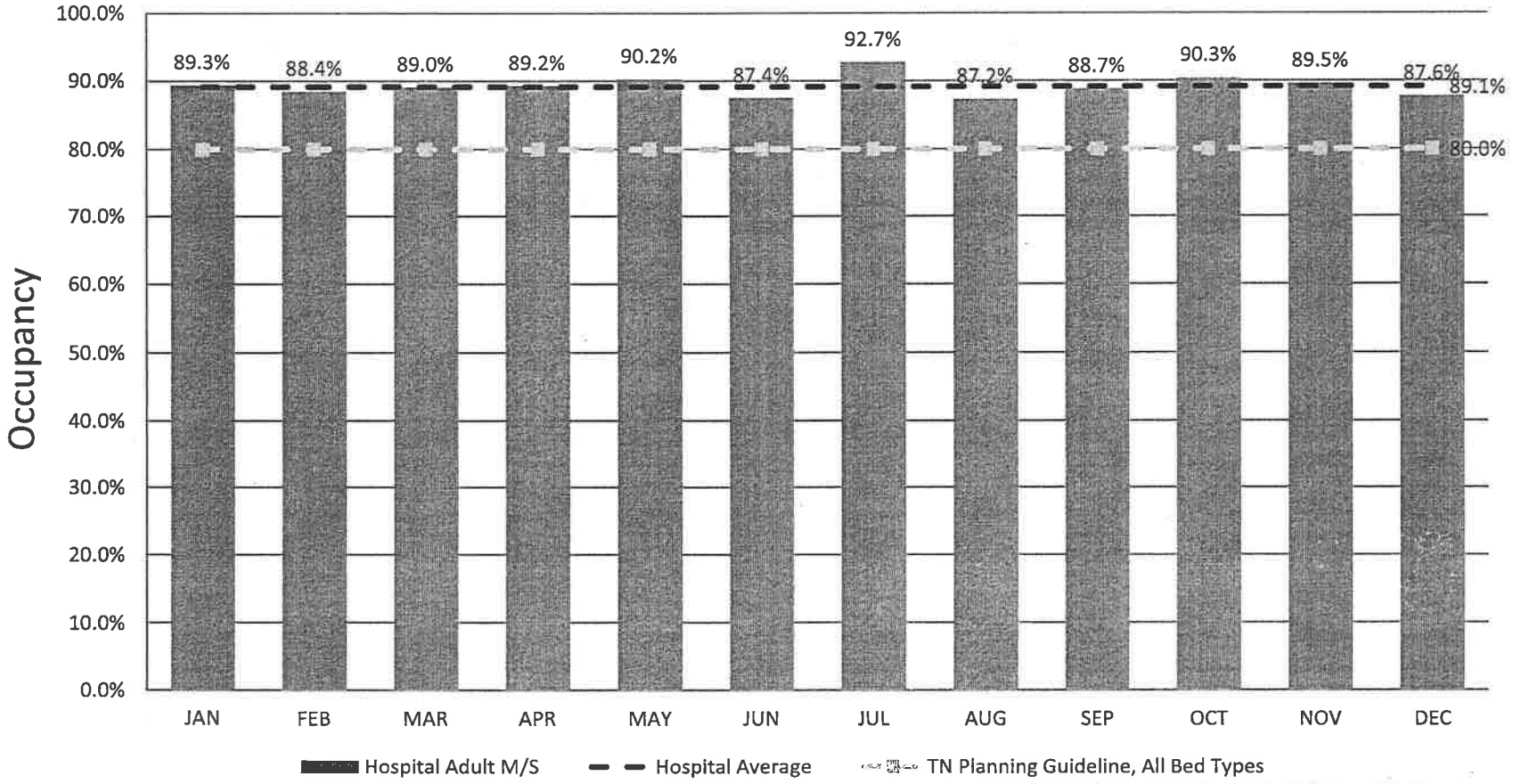
ACUTE-CARE BED NEED PROJECTIONS FOR 2014 AND 2018, BASED ON FINAL 2012 HOSPITAL JARS

COUNTY	2012		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2012 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2012	2014	2018	ADC-2014	NEED 2014	ADC-2018	NEED 2018	LICENSED	STAFFED	LICENSED	STAFFED
Union	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Van Buren	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Warren	11,619	32	45	21,743	21,931	22,287	32	45	33	46	125	48	-79	-2
Washington	167,908	460	575	202,955	206,820	214,435	469	586	486	608	581	581	27	27
Wayne	1,990	6	11	4,701	4,683	4,647	5	11	5	11	80	32	-69	-21
Weakley	6,398	18	27	17,299	17,478	17,808	18	27	18	28	100	65	-72	-37
White	7,122	20	30	10,543	10,722	11,141	20	30	21	31	60	44	-29	-13
Williamson	31,464	86	108	99,271	103,289	111,805	90	112	97	121	185	185	-64	-64
Wilson	34,781	95	119	56,265	58,335	62,267	99	124	105	132	245	245	-113	-113

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. 11/14/2013

Data from Final JAR-Hospitals Schedules F and G. Underlying Tennessee population estimates and projections (2013 Series) from Office of Health Statistics. Projections and estimates for other states obtained from those states.

2013 UTMC-K Med/Surg All Adult Monthly Occupancy (All Units)

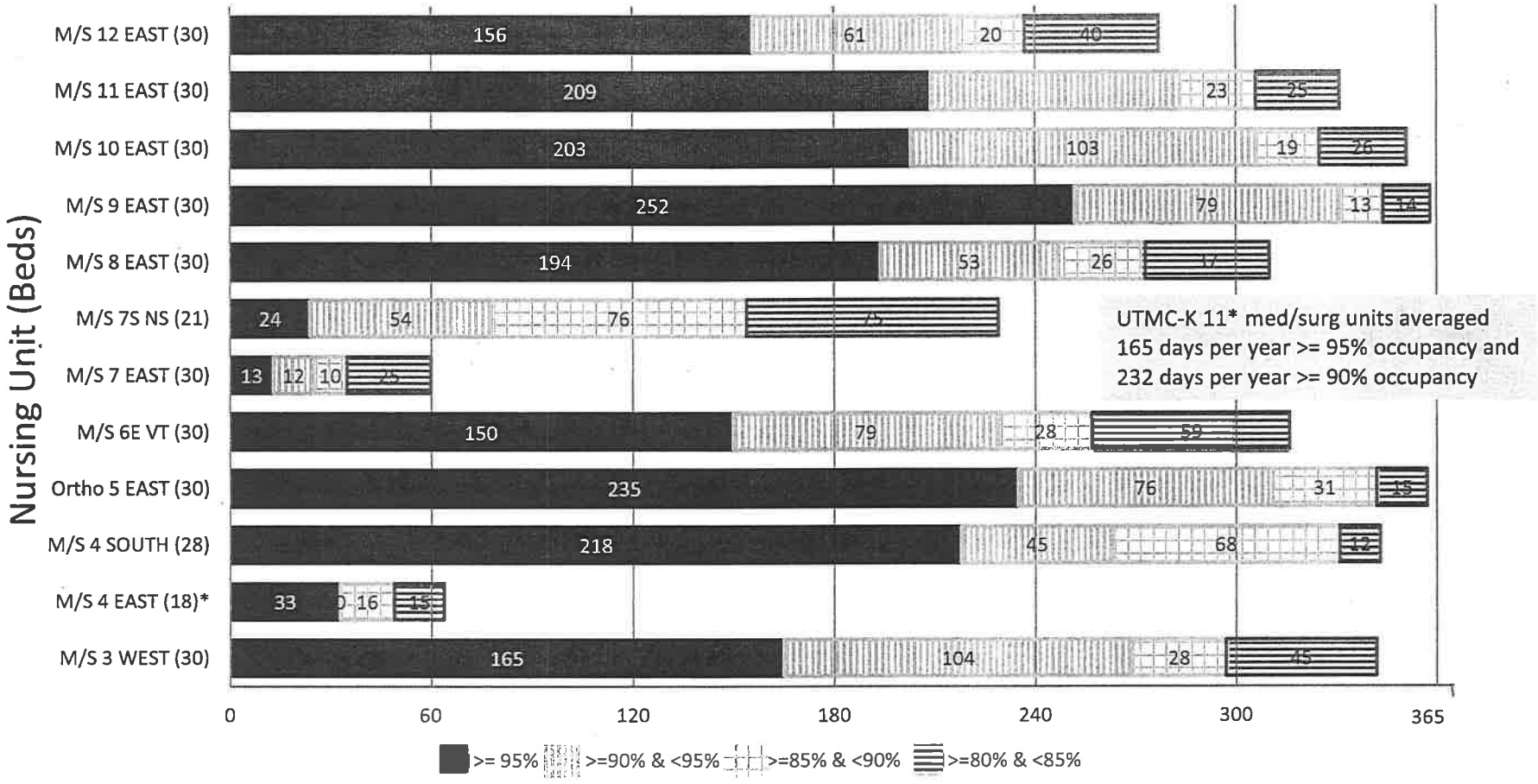


Note: Excludes OB, Peds, PICU, and NICU
Includes Observation Patients
Source: Internal Records

UTMC-K experiences very little monthly variation in its extremely high occupancy

Attachment C, I, Need, 1, Chart 1

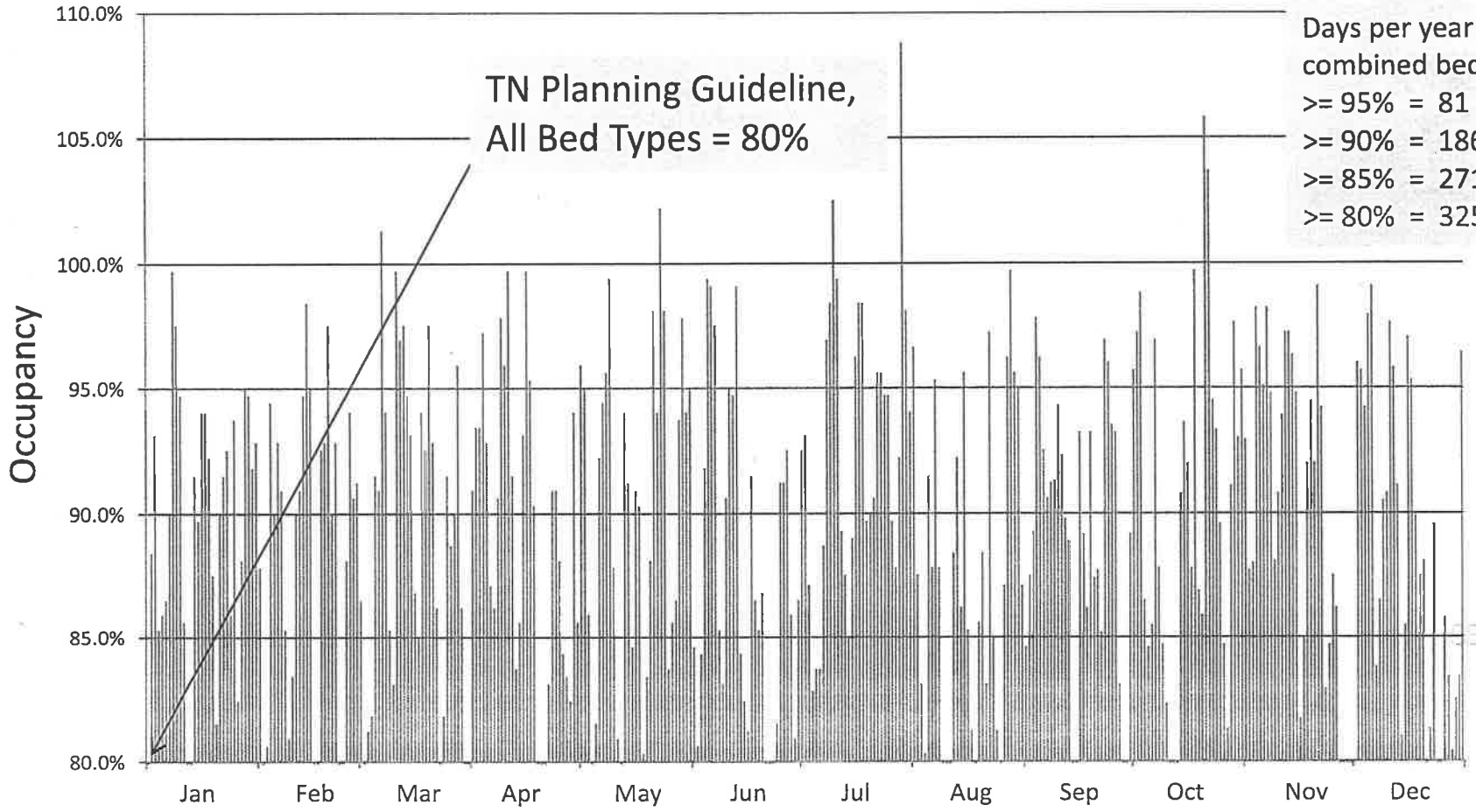
2013 UTMC-K Adult Med/Surg
Days per Year Greater Than 80% Occupancy



*Unit closed Jan – Aug, excluded from summary comments
Note: Excludes OB, Peds, PICU, and NICU
Includes Observation Patients
Source: Internal Records

Attachment C, I, Need, 1, Chart 2

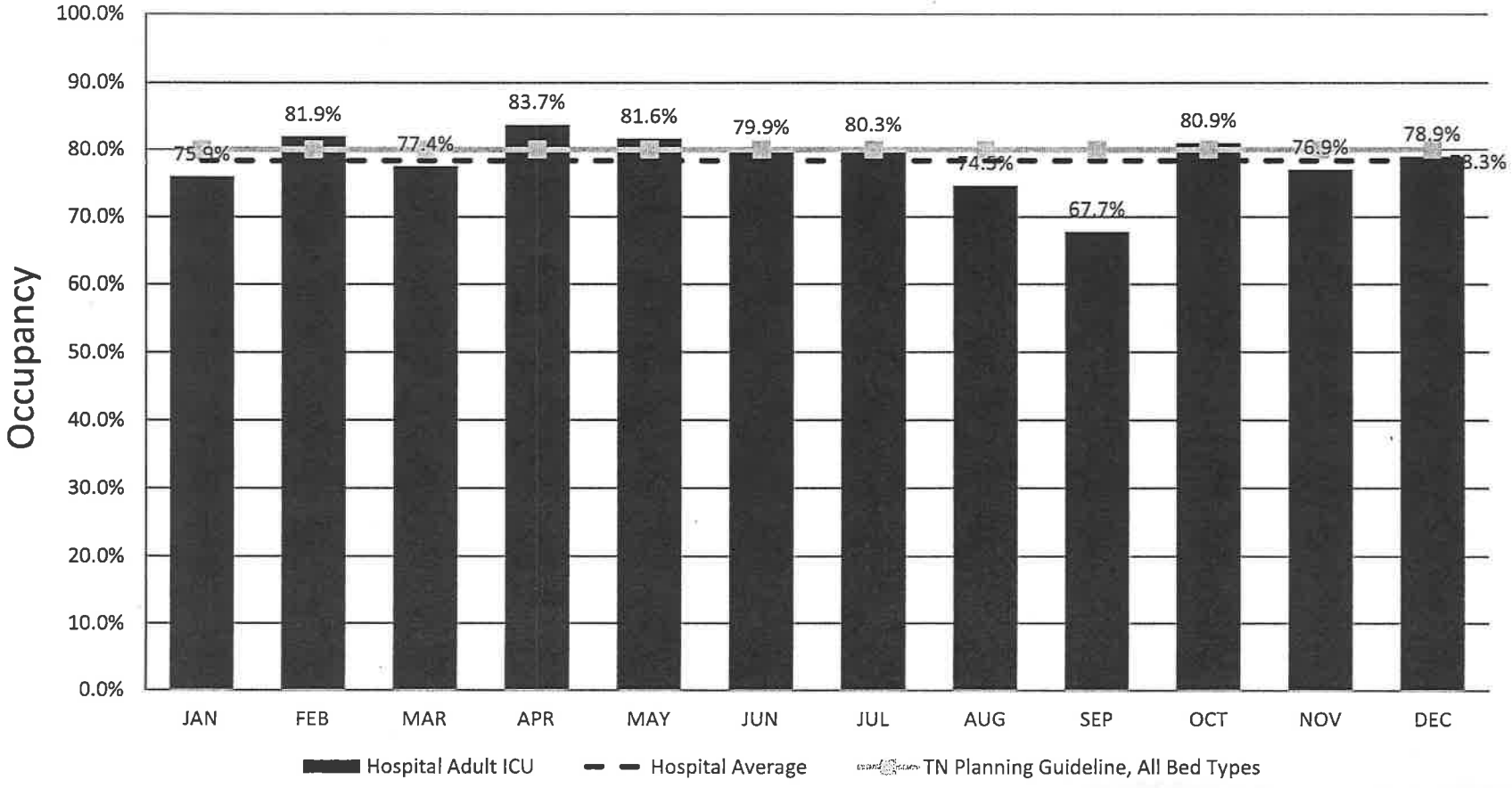
2013 UTMC-K Med/Surg All Adult Daily Occupancy (All Units)



Note: Excludes OB, Peds, PICU, and NICU
Includes Observation Patients
Source: Internal Records

Attachment C, I, Need, 1, Chart 3

2013 UTMC-K Critical Care All Adult Monthly Occupancy (All Units)

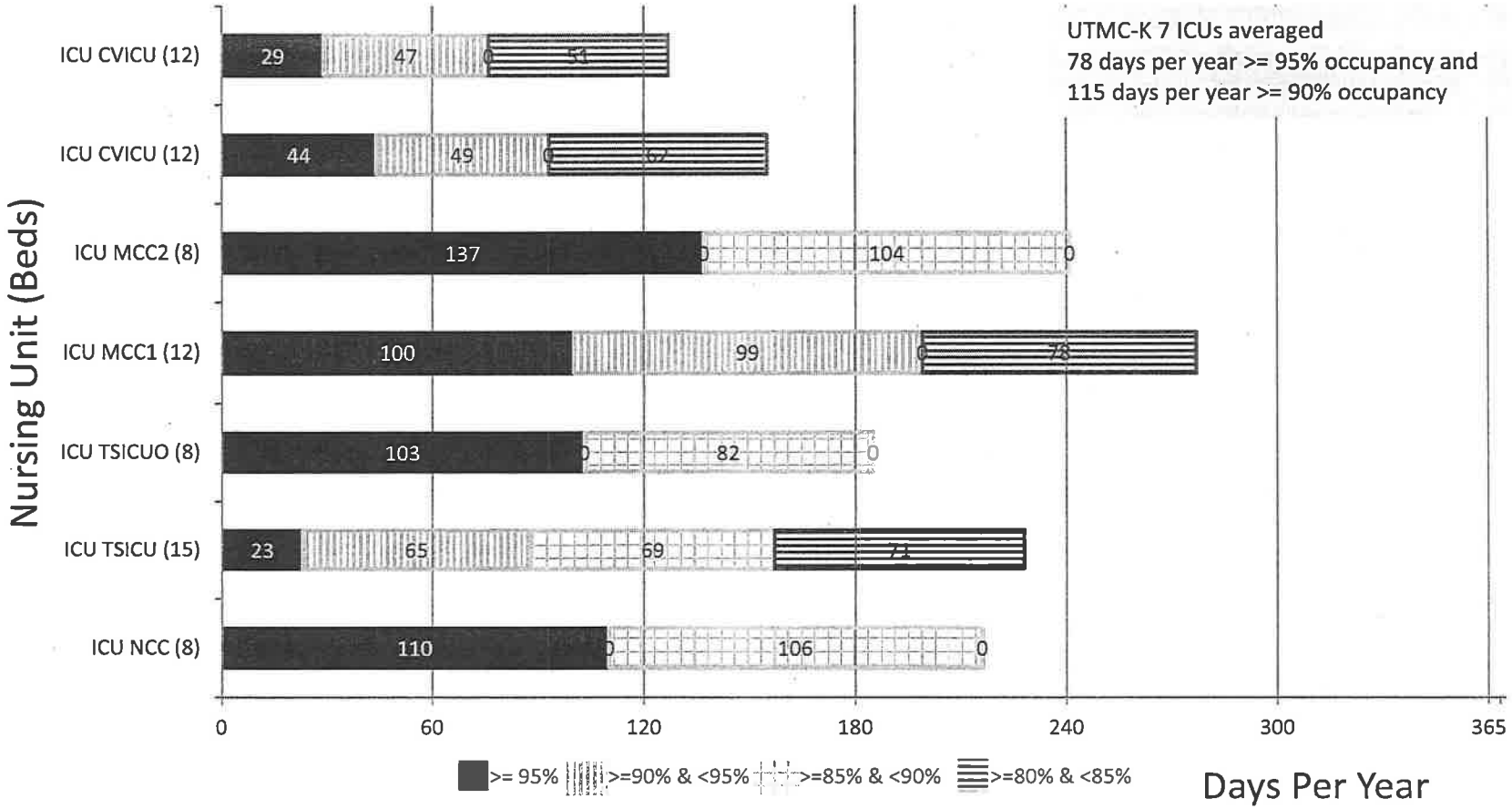


Note: Excludes OB, Peds, PICU, and NICU
Source: Internal Records

UTMC-K experiences very little monthly variation in its extremely high occupancy

Attachment C, I, Need, 1, Chart 4

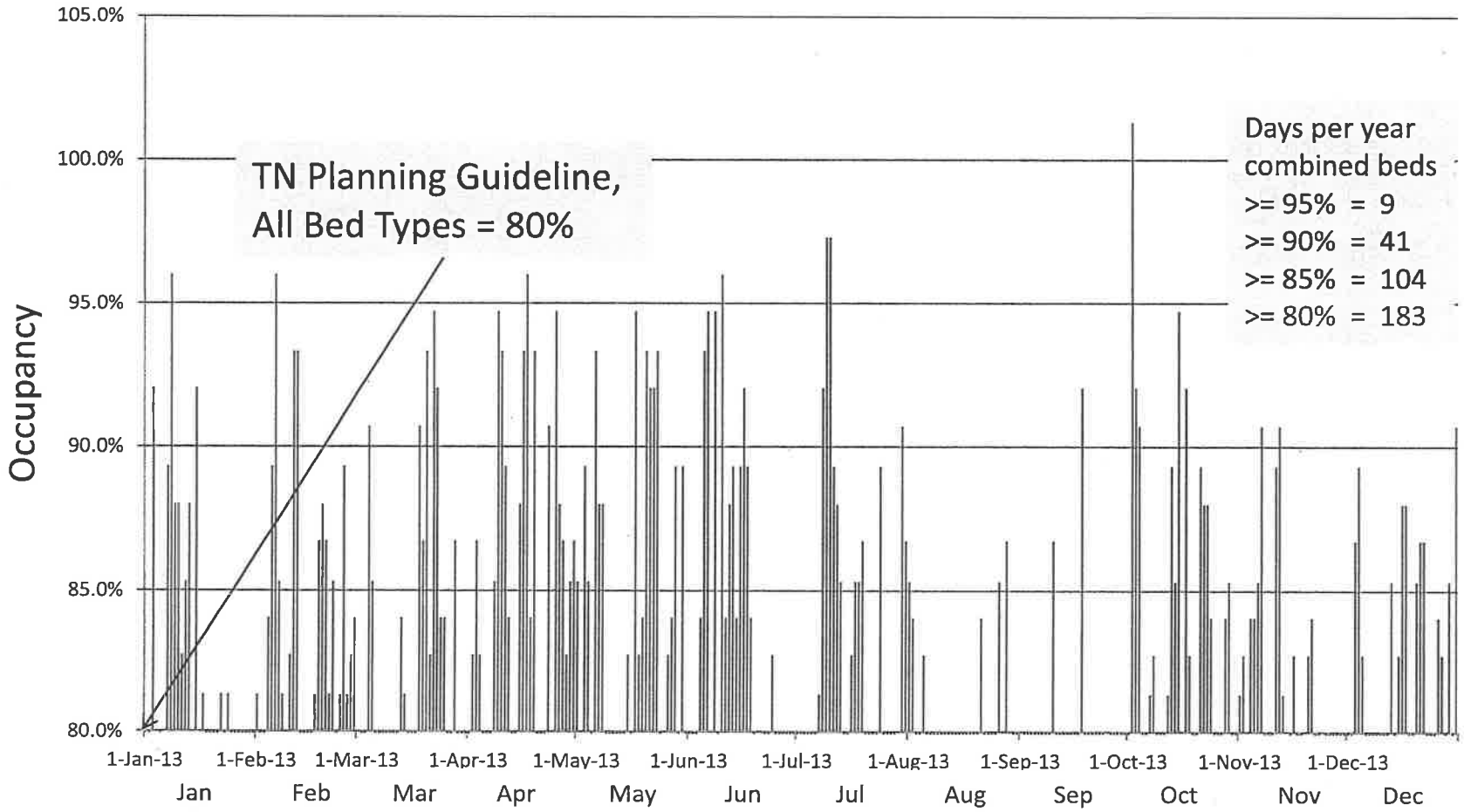
2013 UTMC-K Adult ICUs
Days per Year Greater Than 80% Occupancy



*Unit closed Jan – Aug, excluded from summary comments
Note: Excludes OB, Peds, PICU, and NICU
Source: Internal Records

Attachment C, 1, Need, 1, Chart 5

2013 UTMC-K Critical Care All Adult Daily Occupancy (All Units)



Note: Excludes OB, Peds, PICU, and NICU
Source: Internal Records

Attachment C, 1, Need, 1, Chart 6

2018 UTMC-K Poisson Probability Bed Need - Adult Med/Surg and ICUs

	Nursing Unit	2013 Actual ADC	2013-18 Svc Area Pop Grow	2018 Projected ADC	Poisson Bed Need with Integer Rounding Up			2013 Licensed Beds	2018 Poisson Net Bed Need/(Surplus)		
					90% Probability	95% Probability	99% Probability		90% Probability	95% Probability	99% Probability
1	ICU CVICU	8.1	4.8%	8.5	13	14	16	12	1	2	4
2	ICU CVICU	9.0	4.8%	9.4	14	15	17	12	2	3	5
3	ICU MCC2	6.9	4.8%	7.2	11	12	14	8	3	4	6
4	ICU MCC1	10.5	4.8%	11.0	16	17	19	12	4	5	7
5	ICU TSICUO	6.2	4.8%	6.5	10	11	13	8	2	3	5
6	ICU TSICU	11.9	4.8%	12.5	17	19	21	15	2	4	6
7	ICU NCC	6.7	4.8%	7.0	11	12	14	8	3	4	6
	Subtotal	59.3	4.8%	62.1	92	100	114	75	17	25	39
1	M/S 12 EAST	26.7	4.8%	28.0	35	37	41	30	5	7	11
2	M/S 11 EAST	27.9	4.8%	29.2	37	39	42	30	7	9	12
3	M/S 10 EAST	28.4	4.8%	29.8	37	39	43	30	7	9	13
4	M/S 9 EAST	29.3	4.8%	30.7	38	40	44	30	8	10	14
5	M/S 8 EAST	28.4	4.8%	29.8	37	39	43	30	7	9	13
6	M/S 7S NS	16.8	4.8%	17.6	23	25	28	21	2	4	7
7	M/S 7 EAST	16.6	4.8%	17.4	23	25	28	30	(7)	(5)	(2)
8	M/S 6E VT	27.5	4.8%	28.8	36	38	42	30	6	8	12
9	Ortho 5 EAST	28.8	4.8%	30.2	38	40	43	30	8	10	13
10	M/S 4 SOUTH	26.6	4.8%	27.9	35	37	41	28	7	9	13
11	M/S 4 EAST*	2.1	4.8%	2.2	5	5	6	18	(13)	(13)	(12)
12	M/S 3 WEST	27.9	4.8%	29.2	37	39	42	30	7	9	12
	Subtotal	284.9	4.8%	298.6	376	398	437	319	57	79	118
	Total	344.2	4.8%	360.7	468	498	551	394	74	104	157

*Unit closed Jan-Aug, excluded from calculations

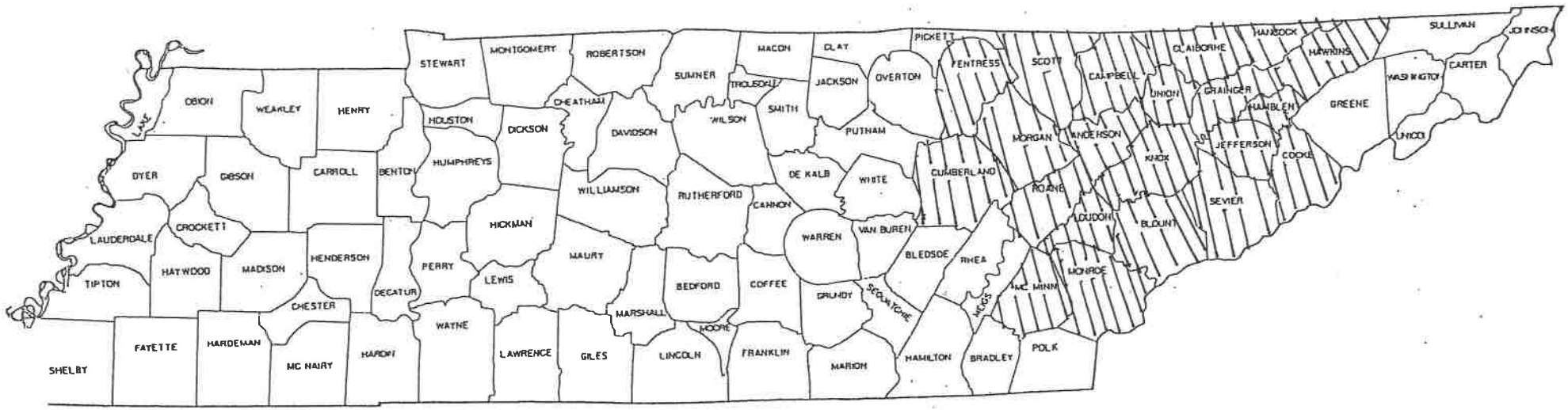
Note: Includes observation patients/days

Sources: Beds and utilization from internal records; population data from TN Office of Health Statistics, rev 6/2013

Attachment C, I, Need, 1, Chart 7

SERVICE AREA

UNIVERSITY OF TENNESSEE MEDICAL CENTER



Attachment C, I, Need, 3

POPULATION AND DEMOGRAPHICS OF SERVICE AREA (Page 1)							
Variable	**Anderson County**	**Blount County**	**Campbell County**	**Claiborne County**	**Cocke County**	**Cumberland County**	**Fentress County**
Current Year (2014), Age 65+	14,531	23,120	7,614	5,880	6,669	15,838	3,566
Projected Year (2018), Age 65+*	16,277	25,829	8,122	6,378	6,871	15,630	3,870
Age 65+, % Change	12.0%	11.7%	6.7%	8.5%	3.0%	-1.3%	8.5%
Age 65+, % Total (PY)	20.9%	19.1%	19.1%	19.2%	17.8%	25.9%	20.4%
CY, Total Population	76,579	128,368	41,474	32,604	36,762	57,815	18,404
PY, Total Population	77,851	135,171	42,566	33,280	38,615	60,292	18,987
Total Pop. % Change	1.7%	5.3%	2.6%	2.1%	5.0%	4.3%	3.2%
TennCare Enrollees (April, 2014)	14,289	19,380	11,805	8,121	10,184	10,735	5,426
TennCare Enrollees as a % of Total Population(CY)	18.7%	15.1%	28.5%	24.9%	27.7%	18.6%	29.5%
Median Age (2010)	43	38	42	41	43	48	42
Median Household Income ('08-'12)	$44,154	$46,347	$31,312	$33,568	$29,764	$37,963	$27,773
Population % Below Poverty Level ('08-'12)	16.7%	12.7%	23.7%	23.0%	26.0%	16.4%	25.4%

Sources: Population, http://health.state.tn.us/statistics/CertNeed.shtml; TennCare enrollment, TennCare Bureau website; Age,TACIR County Profiles website; Income and poverty level, Census Bureau QuickFacts.

Attachment C, I, Need, 4

POPULATION AND DEMOGRAPHICS OF SERVICE AREA (Page 2)							
Variable	**Grainger County**	**Hamblen County**	**Hancock County**	**Hawkins County**	**Jefferson County**	**Knox County**	**Loudon County**
Current Year (2014), Age 65+	4,204	11,269	1,300	11,259	9,972	66,392	12,711
Projected Year (2018), Age 65+*	4,557	12,067	1,431	12,990	11,291	78,354	14,179
Age 65+, % Change	8.4%	7.1%	10.1%	15.4%	13.2%	18.0%	11.5%
Age 65+, % Total (PY)	19.2%	18.4%	21.6%	22.3%	19.9%	16.5%	26.7%
CY, Total Population	23,111	64,108	6,652	57,509	53,729	453,629	50,926
PY, Total Population	23,675	65,570	6,640	58,164	56,872	475,569	53,192
Total Pop. % Change	2.4%	2.3%	-0.2%	1.1%	5.8%	4.8%	4.4%
TennCare Enrollees (April, 2014)	5,118	13,519	2,209	12,015	10,568	65,007	7,366
TennCare Enrollees as a % of Total Population(CY)	22.1%	21.1%	33.2%	20.9%	19.7%	14.3%	14.5%
Median Age (2010)	42	40	43	42	41	37	46
Median Household Income ('08-'12)	$33,185	$39,316	$22,205	$36,419	$38,800	$47,270	$49,602
Population % Below Poverty Level ('08-'12)	20.2%	18.6%	32.7%	16.4%	19.2%	14.2%	14.6%

Sources: Population, http://health.state.tn.us/statistics/CertNeed.shtml; TennCare enrollment, TennCare Bureau website; Age,TACIR County Profiles website; Income and poverty level, Census Bureau QuickFacts.

POPULATION AND DEMOGRAPHICS OF SERVICE AREA (Page 3)								
Variable	McMinn County	Monroe County	Morgan County	Roane County	Scott County	Sevier County	Union County	State of Tennessee
Current Year (2014), Age 65+	9,912	8,938	3,436	11,422	3,541	16,768	3,171	981,984
Projected Year (2018), Age 65+*	10,656	10,340	3,796	12,508	3,857	19,252	3,660	1,102,413
Age 65+, % Change	7.5%	15.7%	10.5%	9.5%	8.9%	14.8%	15.4%	12.3%
Age 65+, % Total (PY)	19.7%	21.5%	17.3%	23.0%	17.6%	19.2%	18.7%	16.1%
CY, Total Population	53,233	46,092	21,848	54,006	21,944	94,833	19,301	6,588,698
PY, Total Population	54,203	48,088	22,004	54,457	21,969	100,362	19,605	6,833,509
Total Pop. % Change	1.8%	4.3%	0.7%	0.8%	0.1%	5.8%	1.6%	3.7%
TennCare Enrollees (April, 2014)	10,660	10,221	4,321	10,013	7,177	16,139	4,553	1,241,028
TennCare Enrollees as a % of Total Population(CY)	20.0%	22.2%	19.8%	18.5%	32.7%	17.0%	23.6%	18.8%
Median Age (2010)	42	42	40	45	38	41	40	N/A
Median Household Income ('08-'12)	$38,944	$36,430	$37,522	$43,017	$29,161	$43,300	$33,456	$44,140
Population % Below Poverty Level ('08-'12)	18.5%	19.3%	19.1%	14.4%	25.8%	13.4%	22.6%	17.3%

Sources: Population, http://health.state.tn.us/statistics/CertNeed.shtml; TennCare enrollment, TennCare Bureau website; Age,TACIR County Profiles website; Income and poverty level, Census Bureau QuickFacts.

Joint Annual Report of Hospitals
Occupancy Rates 2012 Final

Name of Hospital	County	Licensed Beds	Staffed Beds	Inpatient Days	Licensed Beds		Staffed Beds	
					Days Open	Occ. Rate	Days Open	Occ. Rate
Methodist Medical Center of Oak Ridge	Anderson	301	255	48,308	109,865	44.0	93,075	51.9
Ridgeview Psychiatric Hospital and Center	Anderson	16	16	3,372	5,840	57.7	5,840	57.7
Blount Memorial Hospital	Blount	304	238	51,691	110,960	46.6	86,870	59.5
Peninsula Hospital	Blount	155	137	29,332	56,575	51.8	50,005	58.7
Tennova Healthcare - Lafollette Medical Center	Campbell	66	66	11,429	24,090	47.4	24,090	47.4
Jellico Community Hospital, Inc.	Campbell	54	31	4,724	19,710	24.0	11,315	41.7
Claiborne County Hospital	Claiborne	85	39	7,178	31,025	23.1	14,235	50.4
Tennova Healthcare - Newport Medical Center	Cocke	74	36	7,607	27,010	28.2	13,140	57.9
Cumberland Medical Center	Cumberland	189	123	22,073	68,985	32.0	44,895	49.2
Jamestown Regional Medical Center	Fentress	85	54	5,422	31,025	17.5	19,710	27.5
Morristown - Hamblen Healthcare System	Hamblen	167	147	25,436	60,955	41.7	53,655	47.4
Lakeway Regional Hospital	Hamblen	135	65	14,064	49,275	28.5	23,725	59.3
Wellmont Hancock County Hospital	Hancock	10	10	1,199	3,650	32.8	3,650	32.8
Wellmont Hawkins County Memorial Hospital	Hawkins	50	46	3,530	18,250	19.3	16,790	21.0
Tennova Healthcare - Jefferson Memorial Hospital	Jefferson	58	58	8,565	21,170	40.5	21,170	40.5
Fort Sanders Regional Medical Center	Knox	517	378	86,156	188,705	45.7	137,970	62.4
Tennova Healthcare	Knox	111	243	74,903	40,515	184.9	88,695	84.5
University of Tennessee Memorial Hospital	Knox	581	534	136,604	212,065	64.4	194,910	70.1
East Tennessee Children's Hospital	Knox	152	152	40,530	55,480	73.1	55,480	73.1
Parkwest Medical Center	Knox	307	297	75,068	112,055	67.0	108,405	69.2
Mercy Medical Center West	Knox	101	101	16,853	36,865	45.7	36,865	45.7
North Knoxville Medical Center	Knox	108	72	15,128	39,420	38.4	26,280	57.6
Select Specialty Hospital - Knoxville	Knox	35	35	10,153	12,775	79.5	12,775	79.5
Select Specialty Hospital - North Knoxville	Knox	33	33	9,127	12,045	75.8	12,045	75.8
Fort Loudoun Medical Center	Loudon	50	30	6,195	18,250	33.9	10,950	56.6
Woods Memorial Hospital	McMinn	72	48	7,526	26,280	28.6	17,520	43.0
Athens Regional Medical Center	McMinn	118	63	8,366	43,070	19.4	22,995	36.4
Sweetwater Hospital Association	Monroe	59	59	10,251	21,535	47.6	21,535	47.6
Roane Medical Center	Roane	105	36	6,620	38,325	17.3	13,140	50.4
LeConte Medical Center	Sevier	79	69	13,269	28,835	46.0	25,185	52.7
Service Area Average						46.7%		53.6%

Attachment C, I, Need, 5 (1)

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics

3/13/2014

Outstanding Certificate of Need Projects Relating to Hospitals

CON Number	Action	Project Name	County	Project Description	Meeting Date	Expiration Date	Total Project Cost
CN1211-055	A	HMA Fentress County Hospital, LLC d/b/a Jamestown Regional Medical Center	Fentress	Establishment of 6 swing beds and initiation of swing bed services by converting 6 med/surg beds. Licensed bed complement will not change. No other services, will be initiated or discontinue, no major medical equipment is requested, and no renovations.	2/27/2013	4/1/2016	$30,677.00
CN1405-013	A	Lakeway Regional Hospital	Hamblen	To discontinue obstetrical (OB) service. The 16 OB beds will be redistributed to general medical/surgical beds. The 135 licensed bed complement will remain unchanged.	8/27/2014	10/1/2017	$33,000.00
CN1009-040	A	Morristown-Hamblen Hospital	Hamblen	the acquisition of a stationary (fixed) PET/CT unit to replace and upgrade the existing mobile equipment. Construction to modify an existing building on the hospital campus.	12/15/2010	2/1/2015	$4,695,707.00
CN1211-056	A	Metro Knoxville HMA, LLC d/b/a Tennova Healthcare, North Knoxville Medical Center	Knox	Initiation of diagnostic cardiac cath services. The project involves construction and equipping of shell space within the hospital to serve as a dual cardiac cath/vascular lab, support areas for lab, expanded waiting room & additional pre/post-operative	2/27/2013	4/1/2016	$4,377,421.00
CN1312-047	A	Select Specialty Hospital--North Knoxville	Knox	The relocation of 33 long term acute care beds from 900 East Oak Hill Ave., 4th Floor, Knoxville 37917 to leased space at North Knoxville Medical Center, Physicians Plaza B, 1st Floor, Knoxville (Knox Co.), TN 37849.	3/26/2014	5/1/2017	$13,910,744.00
CN1401-002	A	East Tennessee Children's Hospital	Knox	Renovation and expansion of the NICU, Neonatal Abstinence Syndrome Unit, Perioperative Services, and Specialty clinic located on the hospital's campus. No licensed beds affected, no services initiated and no major medical equipment will be purchased.	4/23/2014	6/1/2018	$75,302,000.00
:N1106-019	A	Mercy Health System, Inc. dba Mercy Medical Center, North	Knox	The acquisition of a second linear accelerator to be located and utilized on the Mercy Medical Center, North campus. No new services will be initiated and the radiation therapy services at Mercy Riverside will be relinquished. No inpatient beds involved	10/26/2011	12/1/2014	$4,694,671.00
:N0912-056	A	University of Tennessee Medical Center, The	Knox	The interior build out of appx. 47,428 sf of shelled-in space, on the 3rd and 4th floors of the new hospital wing (CN0801-004A) to house patient rooms for cardiology and cardiothoracic patients. No additional beds, no new services initiated or equipment.	3/24/2010	5/1/2015	$13,941,818.00
:N1005-022	A	University of Tennessee Medical Center	Knox	Construction of an addition to the existing surgery facilities consisting of apprx. 28,000 SF of space to house 13 new operating rooms. Also includes the renovation of existing space in the surgical facilities and the addition of new endovascular suite.	8/25/2010	4/1/2015	$18,432,272.00
:N1404-009	A	Starr Regional Medical Center--Etowah	McMinn	Addtion of 4 geropsychiatric beds to its existing 10-bed inpatient geropsychiatric unit for a 14 bed unit. 4 of the 72 acute care hospital beds at the hospital will be delicensed and the bed complement will remain the same.	7/23/2014	9/1/2017	$1,282,050.00

Attachment C, I, Need, 5 (2)

BARBERMcMURRY
architects since 1915

September 10, 2014

Mr. Scott Castleberry
Director Facilities Planning and Construction Services
University Health System, Inc.
1924 Alcoa Highway
Knoxville, TN 37920

RE: UHS NICU Phase II
Knoxville, Tennessee
BMa Project No. 132000

Dear Mr. Castleberry:

Thank you for selecting BarberMcMurry architects as your Architect-of-Record for the above referenced project. This firm has provided you, under separate cover, a preliminary floor plan showing the building described in the program and narratives. We have reviewed the construction cost estimate. Based on our experience and knowledge of the current healthcare market, it is our professional opinion and belief that the projected cost of $16,031,504.00 to be a reasonable estimate of construction cost. We also agree the $2,404,725.60 contingency amount is appropriate for the scope of work required.

This project will be designed to meet all applicable building codes, as listed below:

State:

1. International Building Code (IBC) - 2012 Edition
2. International Mechanical Code - 2012 Edition
3. International Plumbing Code - 2012 Edition
4. International Gas Code - 2012 Edition
5. International Fire Code - 2012 Edition
6. National Electric Code - 2011 Edition
7. NFPA 101, Life Safety Code - 2012 Edition
8. NFPA Codes (all volumes)- Editions referenced in 2012 NFPA 1
9. FGI Guidelines For Construction and Equipment of Hospital and Medical Facilities- 2010 Edition
10. Tennessee Department of Health Standards for Licensing Hospitals and Institutional General Infirmaries
11. Architectural and Engineering Guidelines for Submission, Approval and Inspection of Occupancies Licensed by the Department of Health, TDOH Office of Health Licensure and Regulation
12. U.L. Building Fire Resistant Directory - Most current Edition
13. U.L. Building Materials Directory - Most current Edition
14. The Americans with Disabilities Act (ADA), 2010 Accessibility Guidelines for Buildings and Facilities
15. North Carolina Accessibility Code, 2004 Edition

505 Market St Suite 300 . Knoxville TN 37902 . p 865.934.1915 . f 865.546.0242 . bma1915.com

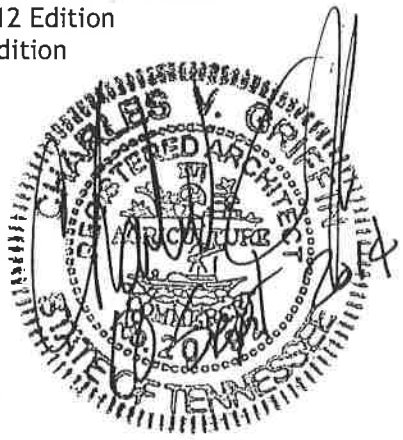
16. Tennessee Code for Energy conservation in New Building Construction

Federal:

1. The Americans with Disabilities Act (ADA), 2010 Accessibility Guidelines for Buildings and Facilities

Local:

1. International Building Code - 2012 Edition
2. 2009 ICC/ANSI A117.1
3. International Mechanical Code - 2012 Edition
4. International Plumbing Code - 2012 Edition
5. National Electric Code - 2008 Edition
6. International Fire Code with Local Amendments - 2012 Edition
7. International Energy Conservation Code - 2012 Edition
8. International Existing Building Code - 2012 Edition
9. International Fuel Gas Code - 2012 Edition



Sincerely,

BarberMcMurry architects

Charles V. Griffin, AIA
President
TN. License No. 020192
cc: File

H:\2013\132000 UT NICU Phase 2\01_Administrative\04_Regulatory\CON Letter_Castleberry_2014-09-10.docx

University Health System, Inc.
2121 Medical Center Way, Suite 200
Knoxville, TN 37920-3257
Main: 865.305.6097
Fax: 865.305.9429

September 15, 2014

Ms. Melanie Hill
Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson State Office Building
500 Deaderick Street, Suite 850
Nashville, TN 37243

RE: University of Tennessee Medical Center CON Project
For additional licensed beds and completion of NICU project

Dear Ms. Hill:

I am the Chief Financial Officer for the University of Tennessee Medical Center ("UTMC"). Please accept this letter as verification that funding for the CON referenced above is available and will be provided from the cash reserves of UTMC. The total project cost is estimated to be in the amount of approximately $27 million.

Please let me know if you have any questions or if additional information is needed.

Sincerely,

Thomas M. Fisher
Sr. Vice President & CFO

/hc

KPMG

UNIVERSITY HEALTH SYSTEM, INC. AND SUBSIDIARIES

Consolidated Financial Statements and Schedules

December 31, 2013 and 2012

(With Independent Auditors' Reports Thereon)

KPMG LLP
Suite 1000
401 Commerce Street
Nashville, TN 37219-2422

Independent Auditors' Report

The Board of Directors
University Health System, Inc.:

We have audited the accompanying consolidated financial statements of University Health System, Inc. and subsidiaries (UHS), which comprise the consolidated balance sheets as of December 31, 2013 and 2012, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

The management of UHS is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to UHS' preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of UHS' internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

KPMG

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of University Health System, Inc. and subsidiaries as of December 31, 2013 and 2012, and the results of their operations and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG LLP

Nashville, Tennessee
March 24, 2014

UNIVERSITY HEALTH SYSTEM, INC.
AND SUBSIDIARIES

Consolidated Balance Sheets

December 31, 2013 and 2012

Assets	2013	2012
Current assets:		
Cash and cash equivalents	$ 69,613,960	64,459,130
Short-term investments	8,156,626	16,213,189
Current portion of assets limited as to use	287,713	205,534
Patient accounts receivable, net of allowance for doubtful accounts of $41,228,000 and $40,393,000 at December 31, 2013 and 2012, respectively	73,347,066	72,489,282
Other receivables	6,937,231	6,647,541
Estimated third-party settlements	16,236,867	19,998,341
Inventories	5,354,591	5,507,111
Prepaid expenses and other current assets	1,197,047	1,440,648
Total current assets	181,131,101	186,960,776
Assets limited as to use, less current portion	14,858,078	11,034,902
Long-term investments	158,122,081	136,115,854
Property and equipment, net	205,459,364	203,440,802
Deferred financing costs, net of accumulated amortization of $517,000 and $425,000 at December 31, 2013 and 2012, respectively	1,988,326	2,080,017
Investments in affiliated organizations	2,333,408	2,647,094
Other assets	7,491,651	5,880,407
Total assets	$ 571,384,009	548,159,852
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term debt	$ 12,347,046	10,325,303
Accounts payable	55,096,388	48,189,513
Accrued payroll and related liabilities	33,638,885	30,267,632
Accrued expenses and other current liabilities	21,673,184	20,687,411
Estimated third-party settlements	8,011,395	7,988,998
Total current liabilities	130,766,898	117,458,857
Long-term debt, less current portion	268,344,281	271,352,198
Other liabilities	19,391,004	15,735,586
Total liabilities	418,502,183	404,546,641
Net assets:		
Unrestricted	144,384,710	135,492,995
Temporarily restricted	3,033,780	3,004,377
Permanently restricted	5,463,336	5,115,839
Total net assets	152,881,826	143,613,211
Total liabilities and net assets	$ 571,384,009	548,159,852

See accompanying notes to consolidated financial statements.

UNIVERSITY HEALTH SYSTEM, INC.
AND SUBSIDIARIES

Consolidated Statements of Operations

Years ended December 31, 2013 and 2012

	2013	2012
Revenue:		
Net patient service revenue	$ 657,185,061	599,093,457
Provision for doubtful accounts	(62,306,309)	(61,277,376)
Net patient service revenue less provision for doubtful accounts	594,878,752	537,816,081
Other revenue	36,565,036	36,995,804
Total revenue	631,443,788	574,811,885
Operating expenses:		
Salaries, wages, and benefits	273,738,240	256,646,078
Medical supplies and drugs	164,893,472	139,614,343
Purchased services	88,648,028	78,773,484
Graduate medical education reimbursed to the University	31,806,637	31,120,692
Insurance and other	29,149,125	28,148,288
Interest	12,277,022	12,218,668
Depreciation and amortization	25,931,840	24,490,737
Total operating expenses	626,444,364	571,012,290
Operating income	4,999,424	3,799,595
Nonoperating gains:		
Contributions	1,922,094	3,606,812
Investment income	5,899,369	7,958,604
Change in fair value of derivative instrument	(3,929,172)	3,995,761
Total nonoperating gains, net	3,892,291	15,561,177
Revenue and gains in excess of expenses and losses	$ 8,891,715	19,360,772

See accompanying notes to consolidated financial statements.

UNIVERSITY HEALTH SYSTEM, INC.
AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Years ended December 31, 2013 and 2012

	Unrestricted net assets	Temporarily restricted net assets	Permanently restricted net assets	Total net assets
Balance at December 31, 2011	$ 116,132,223	3,134,867	5,053,322	124,320,412
Revenue and gains in excess of expenses and losses	19,360,772	—	—	19,360,772
Contributions	—	2,273,242	62,517	2,335,759
Net assets released from restriction used in operations	—	(2,403,732)	—	(2,403,732)
Balance at December 31, 2012	135,492,995	3,004,377	5,115,839	143,613,211
Revenue and gains in excess of expenses and losses	8,891,715	—	—	8,891,715
Contributions	—	1,921,787	347,497	2,269,284
Net assets released from restriction used in operations	—	(1,892,384)	—	(1,892,384)
Balance at December 31, 2013	$ 144,384,710	3,033,780	5,463,336	152,881,826

See accompanying notes to consolidated financial statements.

UNIVERSITY HEALTH SYSTEM, INC.
AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended December 31, 2013 and 2012

	2013	2012
Cash flows from operating activities:		
Increase in total net assets	$ 9,268,615	19,292,799
Adjustments to reconcile increase in total net assets to net cash provided by operating activities:		
Depreciation and amortization	25,931,840	24,490,737
Provision for doubtful accounts	62,306,309	61,277,376
Equity in earnings of affiliated organizations	(2,039,077)	(1,281,993)
Imputed interest on capital lease obligation	1,975,737	1,865,592
Changes in unrealized gains on trading securities	(2,435,254)	(2,909,056)
Realized losses (gains) on trading securities	1,098,461	(795,476)
Change in fair value of derivative instrument	3,929,172	(3,995,761)
Amortization of financing costs	91,691	91,960
Amortization of bond premium	(385,886)	(431,599)
Gain on sale of assets, net	729,391	(75,357)
Changes in assets and liabilities affecting operating activities:		
Patient accounts receivable	(63,164,093)	(65,704,320)
Other receivables	(289,690)	(1,862,372)
Estimated third-party settlements	3,783,871	927,198
Inventories	152,520	679,508
Prepaid expenses and other assets	(1,367,643)	(2,730,256)
Accounts payable	3,937,616	790,025
Accrued payroll and related liabilities	3,371,253	2,490,762
Accrued expenses and other liabilities	712,019	4,334,473
Net cash provided by operating activities	47,606,852	36,454,240
Cash flows from investing activities:		
Proceeds from sale or maturity of investments	307,054,849	243,358,754
Purchases of investments	(323,573,075)	(249,958,175)
Purchases of property and equipment	(19,793,617)	(30,776,548)
Proceeds from the sale of assets	1,197	1,228
Capital distributions from affiliated organization	2,352,763	1,235,756
Net cash used in investing activities	(33,957,883)	(36,138,985)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt	2,493,960	21,994,846
Payments of long-term debt	(10,988,099)	(11,339,053)
Net cash (used in) provided by financing activities	(8,494,139)	10,655,793
Increase in cash and cash equivalents	5,154,830	10,971,048
Cash and cash equivalents at beginning of year	64,459,130	53,488,082
Cash and cash equivalents at end of year	$ 69,613,960	64,459,130

(Continued)

UNIVERSITY HEALTH SYSTEM, INC.
AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended December 31, 2013 and 2012

		2013	2012
Supplemental disclosure of cash flow information:			
Cash paid for interest, net of amount capitalized of $269,798 and $160,497, respectively	$	11,448,645	11,767,814
Noncash investing activities:			
Assets and liabilities resulting from equipment purchases:			
Equipment	$	8,887,373	788,828
Accounts payable		2,969,259	536,931
Capital lease		5,918,114	251,897

See accompanying notes to consolidated financial statements.

HEALTH CARE PROVIDER	CONTRACT(S)
Association of University Radiologists	Radiology Services Agreement
	Neuro-Interventional Radiology Services Agreement
University Anesthesiologists	Anesthesia Services Agreement (CRNA Agreements - 2002)
	Critical Care Coverage Agreement
University General Surgeons	Agreement for Trauma Surgical Services
	Critical Care Coverage Agreement
University Orthopaedic Surgeons	Trauma Services Agreement
Southeastern Emergency Physicians (Team Health)	Emergency Department Coverage Agreement
Regional Neonatal Associates	Services Agreement (NICU)
Neurosurgical Associates	Neurosurgical Trauma Services Agreement
East Tennessee Children's Hospital	Pediatric Intensive Care Services Agreement
Tennessee Donor Services	Statement of Agreement
Diversified Clinical Services	Management and Support Agreement (Clinical Wound Care and Hyperbaric Oxygen Therapy)
NursePro Plus, LLC	Central Line Insertion Services/PICC Insertion Agreement
LabCorp Tennessee, LLC	Hospital Laboratory Services Agreement
Premier Healthcare Solutions, Inc. f/k/a Premier, Inc.	Subscription Agreement

Biotronic Southeast, LLC	Agreement for the Provision of Comprehensive Neurophysiologic Monitoring Services
Medsurant, LLC	Intraoperative Monitoring Services Agreement

PATIENT TRANSFER AGREEMENTS

FacilityName	City	State
Angel Medical Center	Franklin	NC
Asbury Acres Retirement & Health Center	Maryville	TN
Athens Regional Medical Center	Athens	TN
Baptist Health Care Center	Lenoir City	TN
Barnes-Jewish Hospital	St. Louis	MO
Blount Memorial Hospital, Inc	Maryville	TN
Blount Memorial Transitional Care Center	Maryville	TN
Brakebill Nursing Home, Inc.	Knoxville	TN
Brookewood Nursing Center	Decatur	TN
Claiborne County Hospital and Nursing Home	Tazewell	TN
Cleveland Community Hospital (Has been taken over by SkyRidge)	Cleveland	TN
Colonial Hills Nursing Center	Maryville	TN
Cornerstone of Recovery	Louisville	TN
Cumberland Medical Center	Crossville	TN
East Tennessee Children's Hospital	Knoxville	TN
Farragut Health Care Center (aka, Summit View of Farragut)	Knoxville	TN
Fort Loudon Medical Center	Lenoir City	TN
Fort Sanders Regional Medical Center	Knoxville	TN
Hancock Manor Nursing Home	Sneedville	TN
Hillcrest North, Div. of Hillcrest Medical Nursing Inst., Inc.	Knoxville	TN
Holston Health and Rehabilitation Center	Knoxville	TN

Jamestown Regional Medical Center	Jamestown	TN
Jefferson City Health & Rehabilitation	Jefferson City	TN
Jefferson Memorial Hospital (MHS)	Jefferson City	TN
Jellico Community Hospital	Jellico	TN
Jewish Hospital	Louisville	KY
Johnson City Medical Center (Mountain States Health Alliance	Johnson City	TN
Joseph M. Still Burn Centers, Inc. (aka, Doctors Hospital)	Augusta	GA
Knoxville Center for Reproductive Health	Knoxville	TN
LaFollette Memorial Hospital	LaFollette	TN
Lakeway Regional Hospital	Morristown	TN
Laughlin Memorial Hospital	Greeneville	TN
Laurel Manor Health Care Facility	New Tazewell	TN
LeConte Medical Center	Sevierville	TN
Life Care of Morgan County	Wartburg	TN
Loudon Healthcare Center	Loudon	TN
Maryville Healthcare and Rehabilitation Center	Maryville	TN
Methodist Medical Center of Oak Ridge	Oak Ridge	TN
Morristown Dialysis Center	Morristown	TN
Morristown-Hamblen Healthcare System	Morristown	TN
NHC Fort Sanders	Knoxville	TN
NHC Healthcare Knoxville	Knoxville	TN
NHC HealthCare of Oak Ridge	Oak Ridge	TN

NHC Healthcare, Farragut	Knoxville	TN
Newport Medical Center	Newport	TN
Norris Health and Rehabilitation Center	Andersonville	TN
North Knoxville Medical Center	Powell	TN
Northhaven Health Care Center	Knoxville	TN
Parkwest Medical Center	Knoxville	TN
Parkwest Surgery Center, L.P.	Knoxville	TN
Patricia Neal Rehabilitation Center	Knoxville	TN
Peninsula Hospital	Louisville	TN
Physicians Regional Medical Center	Knoxville	TN
Physicians Surgery Center of Knoxville	Knoxville	TN
Presbyterian Homes of TN, Inc. (d/b/a Shannondale Health Care Center)	Knoxville	TN
Roane Medical Center	Harriman	TN
Serene Manor Medical Center	Knoxville	TN
Shriners Burn Hospital	Cincinnati	OH
SkyRidge Medical Center	Cleveland	TN
Spring City Care and Rehab Center	Spring City	TN
Starr Regional Medical Center	Etowah	TN
Sweetwater Hospital	Sweetwater	TN
Sweetwater Nursing Center	Sweetwater	TN
Takoma Regional Hospital, Inc.	Greeneville	TN
Tennova Healthcare	Knoxville	TN
Tennova Medical Center of Campbell County (MHS)	LaFollette	TN
Turkey Creek Medical Center	Knoxville	TN

Urgent Care Travel	Knoxville	TN
Vanderbilt University Medical Center	Nashville	TN
Volunteer Women's Medical Clinic	Knoxville	TN
Wellmont Bristol Regional Medical Center	Bristol	TN
Wellmont Hawkins County Memorial Hospital	Rogersville	TN
Wellmont Holston Valley Medical Center	Kingsport	TN
Wood Presbyterian Home	Sweetwater	TN

EDUCATIONAL AFFILIATION AGREEMENTS (6/2013 – 6/2014)

School Name	Student Discipline
Allied Health Institute	Electrocardiography Tech
American Red Cross – Knox Region	EKG Technician; Phlebotomy Technician
American Red Cross – Knox Region	Nurse Assistant
Armstrong Atlantic State College	Physical Therapy
Belmont University	Occupational Therapy
Boston University	Occupational Therapy
Breakthrough Corporation (Project SEARCH)	Job Skills/Training
Capella University	Nursing
Carson-Newman College	Nursing
Chattanooga State Community College	Diagnostic Medical & Cardiovascular Sonography & Radiation Therapy Technology; Nuclear Medicine Technology
Condensed Curriculum International, Inc.	Clinical Dialysis Technology
Crown College	Small Business & Entrepreneurship
Duke University	Physical Therapy
Eastern Kentucky University	Occupational Therapy
Emory University	Physical Therapy
East Tennessee State University	Nursing
East Tennessee State University	Physical Therapy
East Tennessee State University	MRI Technologist; Computed Tomography Certification Program
Findlay University	Physical Therapy
Florida International University	Occupational Therapy
Georgia Regents University	Physical Therapy
Georgia State University	Physical Therapy
Jefferson College of Health Sciences	Occupational Therapy
Jefferson State Community College	Physical Therapy Assistant
Kaplan University	Nursing

King University	Nursing
Lenoir-Rhyne University	Dietetic Internship Program
Liberty University	Nursing
Lincoln Memorial University	Nursing
Lincoln Memorial University	Physician Assistant
Lincoln Memorial University (with University Anesthesiologists)	Nurse Anesthetists
Medical College of Georgia	Physical Therapy
Medical University of South Carolina	Physical Therapy; Occupational Therapy
Memphis Theological Seminary	Seminary
Mercer University	Physical Therapy
Middle Tennessee State University	Nursing
Milligan College	Occupational Therapy
New York University	Physical Therapy
New York University	Occupational Therapy
Northwestern University	Physical Therapy
Nova Southeastern University	Occupational Therapy
Pellissippi State Community College	Nursing
Pellissippi State Community College	Business & Computer Technology
Roane State Community College	EMT; Health Information Technology; Massage Therapy; Medical Transcription; Occupation Therapy Assistant; Pharmacy Technician; Physical Therapist Assistant; Polysomonography; Radiologic Technology; Respiratory Therapy
Roane State Community College	Nursing
Saint Francis University	Physical Therapy
Samford University	Nursing
South College	Physical Therapist Assistant
South College	Physician Assistant
Southeastern Kentucky Community and Technical College	Respiratory Therapy
Southern Adventist University	Nursing
State University of NY – Delhi	Nursing
Tennessee Board of Regents – Online Degree	Nursing (agreements per student; average 6-8

	students year)
Tennessee College of Applied Technology – Crossville	Surgical Technology
Tennessee College of Applied Technology – Knoxville	Surgical Technology
Tennessee State University	Physical Therapy; Occupational Therapy
Tennessee Technological University	Nursing
Tennessee Wesleyan College	Nursing
Texas Woman's University	Occupational Therapy
Towson University	Occupational Therapy
University of Alabama Birmingham	Physical Therapy; Occupational Therapy
University of Bradford	Health Sciences
University of Findlay	Physical Therapy; Occupational Therapy; Recreational Therapy
University of Houston	Dietetic Internship Program
University of Kentucky	Physical Therapy
University of Miami	Physical Therapy
University of Saint Augustine for Health Sciences	Physical Therapy; Occupational Therapy
University of South Alabama	Nursing
University of South Carolina	Physical Therapy
University of Southern California	Social Work
University of Tennessee Chattanooga	Nursing
University of Tennessee Chattanooga	Occupational Therapy
University of Tennessee Chattanooga	Physical Therapy
University of Tennessee College of Pharmacy	Pharmacy
University of Tennessee Knoxville	Nursing
University of Tennessee Knoxville	Exercise Science
University of Tennessee Knoxville	Social Work
University of Tennessee Knoxville	Speech Language Pathology and Audiology; Physical Therapy; Occupational Therapy
University of Tennessee Health Science Center	Nursing
Utica College	Nursing
Vanderbilt University	Nursing
Virginia College	Surgical Technology; Medical Assistant
Virginia Commonwealth University	Physical Therapy (Doctorate)

Walden University, LLC	Nursing
Walters State Community College	Nursing
Walters State Community College	Paramedic
Walters State Community College	Respiratory Therapy
Walters State Community College	Physical Therapist Assistant
Western Kentucky University	Physical Therapy (Doctorate)

Accreditation/Certification List
UTMC

Program Accredited/Certified	Organization	Begin Date of Accreditation/ Certification – Site Visit	Expiration Date or Expected Return
UTMC	Joint Commission	9/23/2011	**2014**
UTMC	State Licensure	8/20/2008	Pending
Cancer Center			
Cancer Program	ACS,COC 3 year	5/12/2011	5/11/2014
Breast Center	ACS NAPBC ACRA	**4/30/2014** 5/13/11 1/09/2011	4/30/2017 **5/12/14** 2/22/2015(STEREO) **9/22/2014 FDA**
Breast Ultrasound	ACR	**1/09/2014**	**1/9/2017**
Mammography	ACR	9/19-9/22/2011	9/22/2014 (PENDING RENEWAL)
Lab			
LabCorp –Main Lab UTMC	CAP State CLIA AABB	**1/14 & 1/15/2014** 4/30/2012 7/27/2011 1/1/14	1/15/2016 4/30/2014 7/25/2015 12/31/2015
UTMC Point of Care Licenses	CAP State CLIA CMS	**1/14 & 1/15/2014** 9/17/2013 7/22/2013 **4/3/14**	1/15/2016 9/16/2015 7/25/2015 4/2/17
Special Coag Lab Inspection (Hemophilia)	CAP State CLIA	1/14 & 1/15/2014 9/11/2013 12/11/2013	1/26/2016 **10/31/14** 11/30/2015
Radiology			
Magnetic Resonance	ACR	10/14/2011	10/14/2014
Nuc Med Rb82 Generator Inspection	State	5/19/2014- ? One time State visit **1/29 & 1/30/ 14**	n/a
Nuc Med (SIR spheres therapy d/t radiation error)	State	10/15/12-10/16/12	10/14/2015
Radiology	ACR	Online beginning 2012	Online

Program Accredited/Certified	Organization	Begin Date of Accreditation/ Certification – Site Visit	Expiration Date or Expected Return
	State	3/06/2012	**3/06/2014**
Radioactive Material Licensure	State	01/09/2011	**1/08/2014**
Radiology JRCERT Site visit		8/05/2011	8/05/2019
Stereotactic Breast Biopsy	ACR	2/22/2012	2/22/2015
Computed Tomography/CT	ACR	10/12/2008	Not renewed
Positron Emission Tomography	ACR	5/20/2013	5/19/2016
Ultrasound	ACR	6/13/2012	6/13/2015
Other			
Bariatric Center	ACS BSCN	4/23/2013	4/22/2015
Cardiovascular and Pulmonary Rehab	American Association of Cardiac and Pulmonary Rehabilitation	8/31/2012	8/31/2015
Joint Center TJC Certification	Joint Commission Site Visit Intracycle Review	12/06/2012	12/06/2014 12/06/2013 (Call)
Level 1 Trauma Survey	State ACS Consultation	9/10/2013 **2/10 & 2/11/2014**	9/9/2016 N/A
Stroke Advanced Comprehensive TJC Certification	Joint Commission TJC Intra-cycle Certification (Phone Call)	3/20 & 3/21/2013	3/21/2015 **3/20/2014 (Call)**
UT Sleep Center	American Academy of Sleep Medicine	9/09/2011	9/08/2016
Transplant	CMS UNOS- Chart Audits on Deceased Transplant Patients	08/01 & 8/2/2012 12/4 &12/5/2012 4/09/2012 4/23 & 4/24/2013	August 2015 N/A

Board for Licensing Health Care Facilities

State of Tennessee

0000000046

No. of Beds 0581

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

UNIVERSITY HEALTH SYSTEM, INC *to conduct and maintain a*

Hospital THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

Located at 1924 ALCOA HIGHWAY, KNOXVILLE

County of KNOX *, Tennessee.*

This license shall expire MARCH 04 *,* 2015 *, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 4TH *day of* MARCH *,* 2014 *.*

In the Distinct Category(ies) of:
GENERAL HOSPITAL
PEDIATRIC GENERAL HOSPITAL
TRAUMA CENTER LEVEL 1

By Vincent J. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By
COMMISSIONER

Attachment C, III, Orderly Development, 7 (2)

The Joint Commission

December 15, 2011

Joe Landsman, CPA
CEO
The University of Tennessee Memorial Hospital
1924 Alcoa Highway
Knoxville, TN 37920

Joint Commission ID #: 7853
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 12/15/2011

Dear Mr. Landsman:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning September 24, 2011. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

The Joint Commission

The University of Tennessee Memorial Hospital
1924 Alcoa Highway
Knoxville, TN 37920

Organization Identification Number: 7853

Program(s)
Hospital Accreditation

Survey Date(s)
11/03/2011-11/03/2011

Executive Summary

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission

The University of Tennessee Memorial Hospital
1924 Alcoa Highway
Knoxville, TN 37920

Organization Identification Number: 7853

Program(s)
Hospital Accreditation

Survey Date(s)
09/19/2011-09/23/2011

Executive Summary

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), you have met the criteria for Accreditation with Follow-up Survey.

You will have follow-up in the area(s) indicated below:

- As a result of a Condition Level Deficiency, an Unannounced Medicare Deficiency Follow-up Survey will occur. Please address and correct any Condition Level Deficiencies immediately, as the follow-up event addressing these deficiencies will occur within 45 days of the last survey date identified above. The follow-up event is in addition to the written Evidence of Standards Compliance response.
- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission
Summary of Findings

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day this report is posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.03.01	EP1
	EC.02.05.01	EP6
	EC.02.05.09	EP1
	IC.02.02.01	EP1,EP2
	MM.04.01.01	EP13
	PC.01.02.09	EP4
	RI.01.03.01	EP11,EP13
	UP.01.03.01	EP4

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day this report is posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.01.01	EP1
	EM.02.01.01	EP2
	LD.01.03.01	EP2
	LS.02.01.20	EP12
	LS.02.01.30	EP11,EP23
	LS.02.01.35	EP4
	MM.05.01.01	EP1
	MS.01.01.01	EP3,EP16

*** OCO - Observed Corrected Onsite.**

CoP: §482.12 **Tag:** A-0043 **Deficiency:** Condition

Corresponds to: HAP - LD.01.03.01/EP2

Text: §482.12 Condition of Participation: Governing Body

The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.

CoP Standard	Tag	Corresponds to	Deficiency
§482.12(a)(3)	A-0047	HAP - MS.01.01.01/EP3	Standard

CoP: §482.22 **Tag:** A-0338 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(c)(5)(i)	A-0358	HAP - MS.01.01.01/EP16	Standard

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(c)(2)	A-0406	HAP - MM.04.01.01/EP13	Standard

CoP: §482.25 **Tag:** A-0490 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.25 Condition of Participation: Pharmaceutical Services

The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.

CoP Standard	Tag	Corresponds to	Deficiency
§482.25(b)	A-0500	HAP - MM.05.01.01/EP1	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(a)	A-0701	HAP - EC.02.01.01/EP1	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP12, LS.02.01.30/EP11, EP23, LS.02.01.35/EP4	Standard

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CoP: §482.42 **Tag:** A-0747 **Deficiency:** Condition

Corresponds to: HAP - IC.02.02.01/EP1

Text: §482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

CoP: §482.51 **Tag:** A-0940 **Deficiency:** Condition

Corresponds to: HAP - IC.02.02.01/EP2, EC.02.05.01/EP6

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)(2)	A-0955	HAP - RI.01.03.01/EP11, EP13	Standard
§482.51(b)	A-0951	HAP - EC.02.03.01/EP1	Standard

Chapter: Emergency Management

Program: Hospital Accreditation

Standard: EM.02.01.01 ESC 60 days

Standard Text: The hospital has an Emergency Operations Plan.
Note: The hospital's Emergency Operations Plan (EOP) is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities during an emergency (refer to Standards EM.02.02.01, EM.02.02.03, EM.02.02.05, EM.02.02.07, EM.02.02.09, and EM.02.02.11). Although emergencies have many causes, the effects on these areas of the organization and the required response effort may be similar. This 'all hazards' approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the Plan's response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.

Primary Priority Focus Area: Patient Safety

Element(s) of Performance:

2. The hospital develops and maintains a written Emergency Operations Plan that describes the response procedures to follow when emergencies occur. (See also EM.03.01.03, EP 5) 
Note: The response procedures address the prioritized emergencies but can also be adapted to other emergencies that the hospital may experience. Response procedures could include the following:
- Maintaining or expanding services
- Conserving resources
- Curtailing services
- Supplementing resources from outside the local community
- Closing the hospital to new patients
- Staged evacuation
- Total evacuation

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Building Tour at University Cancer Specialists (908 West Fourth North Street, Morristown, TN) site.
In discussion with the staff at the facility, which is approximately 49 miles from the main hospital, it was noted there is no Emergency Operations Plan for the facility. The hospital plan does not address what is to occur in this facility in the event of a disaster either.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.01.01 ESC 60 days

Standard Text: The hospital manages safety and security risks.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

1. The hospital identifies safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. 

Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of annual proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. (See also EC.04.01.01, EP 14)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
Inside of OR # 21, there were approximately 4 large extension cords being utilized for various equipment. The extension cords had four-gang outlet conduit boxes lying on the floor used to plug in equipment.

Chapter: Environment of Care
Program: Hospital Accreditation
Standard: EC.02.03.01 ESC 45 days
Standard Text: The hospital manages fire risks.
Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

1. The hospital minimizes the potential for harm from fire, smoke, and other products of combustion. 

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 1
§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
At the entrance to the Heart Hospital on the third floor, two 120 volt junction box covers were not in place. This was observed but corrected on site.

Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
Inside the storage room on the third floor of the Heart Hospital, one junction box cover had been removed inside of the large storage room across from the nurses station.

Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
At the MCC1 staff locker room, a junction box cover was missing. This was observed but corrected on site.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.01 ESC 45 days

Standard Text: The hospital manages risks associated with its utility systems.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

6. In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, and filtration efficiencies. 3
Note: Areas designed for control of airborne contaminants include spaces such as operating rooms, special procedure rooms, delivery rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, pulmonary or laryngeal tuberculosis), patients in 'protective environment' rooms (for example, those receiving bone marrow transplants), laboratories, pharmacies, and sterile supply rooms. For further information, see Guidelines for Design and Construction of Health Care Facilities, 2010 edition, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 6
§482.51 - (A-0940) - §482.51 Condition of Participation: Condition of Participation: Surgical Services
This Condition is NOT MET as evidenced by:
Observed in Individual Tracer at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
During patient tracer activity, review of the airflow/pressure relationships in central sterilization for the main hospital operating room suites revealed that the clean area was negative compared to the dirty area instead of positive. The clean area was also negative compared to an adjacent hallway instead of positive.

Observed in Individual Tracer at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
During patient tracer activity, review of the airflow/pressure relationships in several rooms in the operative and peri-operative services in the Day Surgery area revealed several instances where the airflow/pressure relationships were not correct. Operating room 2 was negative instead of positive with respect to the adjacent hallway. In central sterilization the clean room was negative instead of positive with respect to the adjacent hallway and the dirty room was neutral instead of negative with respect to the adjacent hallway.

Observed in Individual Tracer at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
During patient tracer activity, review of the endoscope disinfection process in the Day Surgery area revealed that both cleaning and disinfection are done in the same room. There is no physical barrier between the dirty area and the clean area. The scopes are washed in tubs placed on a cabinet immediately adjacent to the disinfection machine. In the absence of physical barrier separation of dirty from clean areas, the current arrangement does not provide for sufficient compensatory measures such as adequate spatial separation and appropriate airflow characteristics.

Observed in Individual Tracer at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
During patient tracer activity, review of the endoscope disinfection process at the main hospital endoscopy suite revealed that cleaning and disinfection are done in the same room. There is no physical barrier between the clean area and the dirty area. The first disinfection machine is located about 3 - 4 feet from a sink used to wash the scopes. In the absence of physical barrier separation of dirty from clean areas, the current arrangement does not provide for sufficient compensatory measures such as adequate spatial separation, modified work practices and appropriate airflow characteristics.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.09 ESC 45 days

Standard Text: The hospital inspects, tests, and maintains medical gas and vacuum systems. Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

1. In time frames defined by the hospital, the hospital inspects, tests, and maintains critical components of piped medical gas systems, including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets. These activities are documented. (See also EC.02.05.01, EP 3)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site. Inside of the main Security Office, the Main Medical Gas Alarm panel had been turned off. Once turned back on, it functioned appropriately. Another Main Med Gas panel was located in the Engineering Office which is manned 24/7 also.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01 ESC 45 days

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

1. The hospital implements infection prevention and control activities when doing the following: Cleaning and performing low-level disinfection of medical equipment, devices, and supplies. * 
Note: Low-level disinfection is used for items such as stethoscopes and blood glucose meters. Additional cleaning and disinfecting is required for medical equipment, devices, and supplies used by patients who are isolated as part of implementing transmission-based precautions.
Footnote *: For further information regarding cleaning and performing low-level disinfection of medical equipment, devices, and supplies, refer to the Web site of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/ncidod/dhqp/sterile.html (Sterilization and Disinfection in Healthcare Settings).

Scoring Category : C
Score : Insufficient Compliance

2. The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4) 
Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.
Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the Web site of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Condition is NOT MET as evidenced by:
Observed in Tracer Activities at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
When conducting tracer activities in the neonatal intensive care unit, a mattress was found to be tattered & torn. As such, the hospital potentially exposed its infants to device-transmitted infections as the disruptions in the fabric of this mattress made it impossible to terminally clean the mattress between patients.

Observed in Tracer Activities at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
When conducting tracer activities in the neonatal intensive care unit, a SECOND mattress was found to be tattered & torn. As such, the hospital potentially exposed its infants to device-transmitted infections as the disruptions in the fabric of this mattress made it impossible to terminally clean the mattress between patients.

Observed in Tracer Activities at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
When conducting tracer activities in the neonatal intensive care unit, a THIRD mattress was found to be tattered & torn. As such, the hospital potentially exposed its infants to device-transmitted infections as the disruptions in the fabric of this mattress made it impossible to terminally clean the mattress between patients.

EP 2
§482.51 - (A-0940) - §482.51 Condition of Participation: Condition of Participation: Surgical Services
This Condition is NOT MET as evidenced by:
Observed in Individual Tracer at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
During patient tracer activity, review of the process for flash sterilization revealed that when this process was required, the contaminated instrument was washed in the sink used by staff to scrub in preparation for surgery. Contaminated instruments must be cleaned in an area designated for that purpose using equipment and cleaning reagents appropriate for this process.

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.01.03.01 ESC 60 days

Standard Text: The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

Primary Priority Focus Area: Organizational Structure

Element(s) of Performance:

2. The governing body provides for organization management and planning. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.12 - (A-0043) - §482.12 Condition of Participation: Condition of Participation: Governing Body
This Condition is NOT MET as evidenced by:
Observed in Leadership Session at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
The governing body/leadership did not ensure that the following Conditions of Participation were met as determined through observations, documentation, and staff interviews: 482.42/IC.02.02.01 - EP1: torn mattresses in the neonatal intensive care unit; 482.51/IC.02.02.01- EP2: cleaning surgical instruments in areas not designated for that purpose; EC.02.05.01 - EP6: Incorrect airflow/pressure relationships in operating and central sterilization rooms, insufficient separation of clean from dirty areas in endoscopy disinfection rooms, and deficiencies in obtaining procedural and anesthesia consents.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20 ESC 60 days

Standard Text: The hospital maintains the integrity of the means of egress.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

12. The corridor width is not obstructed by wall projections. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.3.3) 4 OCO
Note: When corridors are 6 feet wide or more, The Joint Commission permits certain objects to project into the corridor, such as hand rub dispensers or computer desks that are retractable. They must be no more than 36 inches wide and cannot project more than 6 inches into the corridor. These items must be installed at least 48 inches apart and above the handrail height. (For full text and any exceptions, refer to: NFPA 101-2000: 18/19.2.3.3)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 12
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
On the 12th floor across from the nurses station, one wooden box for customer comments was in the egress corridor. The box extended into the corridor approximately eight inches. This was removed during survey.

Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
At the Recovery Department on three south, the patient information television projected more than 6" into the egress corridor.

Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
At the EVR Department near room # 16, the patient record box/mail box projected greater than 6" into the egress corridor.

Chapter:	Life Safety
Program:	Hospital Accreditation
Standard:	LS.02.01.30 ESC 60 days
Standard Text:	The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.
Primary Priority Focus Area:	Physical Environment

Element(s) of Performance:

11. Corridor doors are fitted with positive latching hardware, are arranged to restrict the movement of smoke, and are hinged so that they swing. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 1 inch. Roller latches are not acceptable.
Note: For existing doors, it is acceptable to use a device that keeps the door closed when a force of 5 foot-pounds are applied to the edge of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.6.3.2, 18/19.3.6.3.1, and 7.2.1.4.1)

Scoring Category : C
Score : Insufficient Compliance

23. Doors in smoke barriers are self-closing or automatic-closing, constructed of 1 3/4-inch or thicker solid bonded wood core or equivalent, and fitted to resist the passage of smoke. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 3/4 inch. Doors do not have nonrated protective plates more than 48 inches above the bottom of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.5, 18/19.3.7.6, and 8.3.4.1)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 11
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
At the Recovery Department corridor on the third floor, the corridor door latches for both doors entering Recovery were not functioning. Both latches were corrected during survey.

Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
At room 389 and 390 in the Heart Hospital building, the doors to the patient rooms had greater than 1/8" gap at the wing door and regular patient room door. This was corrected during survey.

Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
Inside of the main Surgery Department, OR room # 23, and room # 24 had gaps larger than 1/8" at the meeting edges where the wing door met the main entrance door to the rooms.

Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
At smoke compartment 2.3, the patient room doors (6 total) were not equipped with positive latching hardware. This area was not designated as a suite on the life safety drawings.

EP 23
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
The smoke barrier doors at OR # 14 did not latch when tested. This was corrected during survey.

Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
At the entrance to the Heart Hospital on the third floor, the gap between the smoke barrier doors was greater than 1/8". This was corrected during survey.

Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
The smoke barrier doors on the second floor at the Vascular Access Coordinator's office had a gap at the meeting

edges larger than 1/8".

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.35 ESC 60 days

Standard Text: The hospital provides and maintains systems for extinguishing fires.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

4. Piping for approved automatic sprinkler systems is not used to support any other item. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.2) 

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 4
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
On the 11th floor inside the Clean Utility Room, the ceiling grid wiring was attached to the fire sprinkler piping. This was removed during survey.

Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
Inside the 10th floor electrical room, a 3/4 inch conduit was attached to the sprinkler pipe with wire at three locations.

Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
At room 1028, low voltage wires were attached to the fire sprinkler pipe.

Observed in Building Tour at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
On the 9th floor at the electrical room, low voltage cabling was attached to the fire sprinkler piping.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.01.01.01 ESC 60 days

The Joint Commission
Findings

Standard Text: Medical staff bylaws address self-governance and accountability to the governing body.

Primary Priority Focus Area: Credentialed Practitioners

Element(s) of Performance:

3. Every requirement set forth in Elements of Performance 12 through 36 is in the medical staff bylaws. These requirements may have associated details, some of which may be extensive; such details may reside in the medical staff bylaws, rules and regulations, or policies. The organized medical staff adopts what constitutes the associated details, where they reside, and whether their adoption can be delegated. Adoption of associated details that reside in medical staff bylaws cannot be delegated. For those Elements of Performance 12 through 36 that require a process, the medical staff bylaws include at a minimum the basic steps, as determined by the organized medical staff and approved by the governing body, required for implementation of the requirement. The organized medical staff submits its proposals to the governing body for action. Proposals become effective only upon governing body approval. (See the 'Leadership' (LD) chapter for requirements regarding the governing body's authority and conflict management processes.)
Note: If an organization is found to be out of compliance with this Element of Performance, the citation will occur at the appropriate Element(s) of Performance 12 through 36.

Scoring Category : A
Score : Insufficient Compliance

16. For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oralmaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. (For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6-11.)
Note 1: The definition of 'physician' is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).
Note 2: The requirements referred to in this element of performance are, at a minimum, those described in the element of performance and Standard PC.01.02.03, EPs 4 and 5.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
§482.12(a)(3) - (A-0047) - [The governing body must:]

(3) Assure that the medical staff has bylaws;
This Standard is NOT MET as evidenced by:
Observed in Medical Management Session at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
Review of the medical staff bylaws revealed that documentation of the requirements of EP 16 into the bylaws had not been completed by the organized medical staff and approved by the governing body.

EP 16
§482.22(c)(5)(i) - (A-0358) - (i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
This Standard is NOT MET as evidenced by:
Observed in Medical Management Session at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
Review of the current language of the bylaws regarding medical histories and physical exams revealed that the bylaws did not sufficiently address who may do a history and physical or the timeframe requirments for completing the history and physical and updates. It also did not address basic information regarding any distinctions between inpatient and outpatient exams or any requirements for countersignatures.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.04.01.01 ESC 45 days

Standard Text: Medication orders are clear and accurate.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

13. The hospital implements its policies for medication orders. 

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 13
§482.23(c)(2) - (A-0406) - (2) With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accordance with State law, and who is responsible for the care of the patient as specified under §482.12(c).
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
During patient tracer activity, review of medication orders revealed a titration order for Fentanyl IV 2.5 mg/100 ml; titrate, Ramsey 3. This order does not include the "titration schedule" as required by hospital policy.

Observed in Individual Tracer at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
During patient tracer activity, review of the medication ordering process revealed that the hospital used a standing order for pre-operative IVs. Hospital policy required that after standing orders were implemented, they were to be authenticated by the physician. Discussion with staff revealed that currently the actual standing order pre-printed form was not included in the medical record and that therefore physicians were not authenticating these orders as hospital policy required.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.05.01.01 ESC 60 days

Standard Text: A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

1. Before dispensing or removing medications from floor stock or from an automated storage and distribution device, a pharmacist reviews all medication orders or prescriptions unless a licensed independent practitioner controls the ordering, preparation, and administration of the medication or when a delay would harm the patient in an urgent situation (including sudden changes in a patient's clinical status), in accordance with law and regulation. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.25(b) - (A-0500) - §482.25(b) Standard: Delivery of Services

In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
During patient tracer activity, review of the medical record revealed that the order for antibiotics in the pre-operative area had not been scanned to the pharmacy as required and that the antibiotics had been started without pharmacy review of orders.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: UP.01.03.01 ESC 45 days

Standard Text: A time-out is performed before the procedure.

Primary Priority Focus Area: Patient Safety

Element(s) of Performance:

4. During the time-out, the team members agree, at a minimum, on the following:
- Correct patient identity
- The correct site
- The procedure to be done

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
Observed in Individual Tracer at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site.
During patient tracer activity, observation of a time-out revealed that the patient identification process did not include viewing the patient's armband as required by the hospital's patient identification policy.

Observed in Individual Tracer at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site.
During patient tracer activity, observation of the time-out revealed that the specification of patient identity was limited to the medical record number and did not include patient name and birthdate as required by hospital policy.

Observed in Tracer Activities at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site.
The time out which was observed by the surveyor in the cardiac cath lab did not include positive patient identification. During the time out, the circulator stood at the foot of the bed and announced, "Time out. This is ...(patient's name) and we are doing a left heart cath. Does everybody agree?" The circulator did not compare any piece of paper, such as the consent form, against the armband. She also did not announce the patient's medical record number or date of birth as required by hospital policy. When the armband verification WAS verified (pre-procedurally & in another area), the physician was not present. At the actual time out being described, no staff member compared the medical record number of date of birth against any source document, such as the consent and/or armband. The hospital failed to follow its own policy for patient identification during the time out.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.09 ESC 45 days

Standard Text: The hospital assesses the patient who may be a victim of possible abuse and neglect.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

4. The hospital uses its criteria to identify possible victims of abuse and neglect upon entry into the hospital and on an ongoing basis.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
Observed in Individual Tracer at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site.
During patient tracer activity in the Emergency room, review of the patient assessment process revealed no evidence that the patient had been screened for abuse. Subsequent discussion with staff revealed that although there was a formal process for screening for abuse and documenting the result for admitted patients, the Emergency department did not have a similar process in place.

Chapter: Rights and Responsibilities of the Individual

Program: Hospital Accreditation

Standard: RI.01.03.01 ESC 45 days

Standard Text: The hospital honors the patient's right to give or withhold informed consent.

Primary Priority Focus Area: Rights & Ethics

Element(s) of Performance:

11. The informed consent process includes a discussion about reasonable alternatives to the patient's proposed care, treatment, and services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services. 3

Scoring Category : A
Score : Insufficient Compliance

13. Informed consent is obtained in accordance with the hospital's policy and processes and, except in emergencies, prior to surgery. (See also RC.02.01.01, EP 4) 4

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 11
§482.51(b)(2) - (A-0955) - (2) A properly executed informed consent form for the operation must be in the patient's chart before surgery, except in emergencies.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
The surgical consent form for a patient in Labor & Delivery had no documented risks of NOT performing the planned surgical procedure. This is not included in the template nor was it found in any progress notes. The hospital has a new surgical consent form which is now with the Forms Committee which DOES contain this information; however, this particular record was lacking that information.

Observed in Tracer Activities at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
The surgery consent for a patient who received a coronary artery bypass surgery did not include risks related to not receiving the proposed surgery.

EP 13
§482.51(b)(2) - (A-0955) - (2) A properly executed informed consent form for the operation must be in the patient's chart before surgery, except in emergencies.
This Standard is NOT MET as evidenced by:
Observed in Breast Center at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
The patient was having a Stereotactic Breast Biopsy. The witness to the consent for the procedure was noted by three initials. Hospital policy requires the name of the person witnessing the consent.

Observed in Individual Tracer at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
During patient tracer activity, review of the medical record revealed that there was no procedural or sedation consent form obtained for a patient who had a non emergent chest tube inserted.

Observed in Individual Tracer at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
During patient tracer activity, review of the consenting process for anesthesia revealed that the patient had signed the consent form, which covered both the procedure itself and anesthesia, before the anesthesiologist had spoken to the patient. Hospital policy required that the patient should not sign the consent form until all of their questions had been answered by the provider of care.

Observed in Individual Tracer at The University of Tennessee Memorial Hospital (1924 Alcoa Highway, Knoxville, TN) site for the Hospital deemed service.
Review of a second medical record revealed that the patient had signed the consent form, which covered both the procedure itself and anesthesia, before the anesthesiologist had spoken to the patient. Hospital policy required that the patient should not sign the consent form until all of their questions had been answered by the provider of care.

The Joint Commission

December 15, 2011

Re: # 7853
CCN: #440015
Program: Hospital
Accreditation Expiration Date: December 24, 2014

Joe Landsman
CEO
The University of Tennessee Memorial Hospital
1924 Alcoa Highway, Box 25
Knoxville, Tennessee 37920

Dear Mr. Landsman:

This letter confirms that your September 19, 2011 - September 23, 2011 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on November 18, 2011 and November 29, 2011 and the successful on-site Medicare Deficiency Follow-up event conducted on November 03, 2011, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of September 24, 2011. We congratulate you on your effective resolution of these deficiencies.

§482.12 Condition of Participation: Governing Body
§482.22 Condition of Participation: Medical staff
§482.23 Condition of Participation: Nursing Services
§482.25 Condition of Participation: Pharmaceutical Services
§482.41 Condition of Participation: Physical Environment
§482.42 Condition of Participation: Infection Control
§482.51 Condition of Participation: Surgical Services

The Joint Commission is also recommending your organization for continued Medicare certification effective September 24, 2011. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation also applies to the following location(s):

The University of Tennessee Memorial Hospital
1924 Alcoa Highway, Knoxville, TN, 37920

University Cancer Specialists

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

908 West Fourth North Street, Morristown, TN, 37814

UT Medical Center/Rehab @ Halls
4005 Fountain Valley Dr. Suite 400, Knoxville, TN, 37918

UT Medical Center/Rehab @ Hardin Valley
2587 Willow Point Way, Knoxville, TN, 37932

UT Medical Center/Rehab @ Northshore
9625 Kroger Park Dr. Suite 100, Knoxville, TN, 37922

UT Medical Center/Rehab @ Seymour
11546 Chapman Highway, Seymour, TN, 37865

UT Outpatient Diagnostic Center at Turkey Creek
11440 Parkside Drive, Ste 204 Plaza 2, Knoxville, TN, 37934

UT Physical Therapy, Loudon Clinic
2480 Highway 72 N, Loudon, TN, 37774

UT Sleep Center
420 W. Morris Blvd, Suite 400-H, Morristown, TN, 37813

We direct your attention to some important Joint Commission policies. First, your Medicare report is publicly accessible as required by the Joint Commission's agreement with the Centers for Medicare and Medicaid Services. Second, Joint Commission policy requires that you inform us of any changes in the name or ownership of your organization, or health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

SEP 15 14 2:52

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF KNOX

Teresa Levey, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Teresa Levey
SIGNATURE

Sr. VP & Chief Administrative Officer
TITLE

Sworn to and subscribed before me this 12 day of September, 2014 a Notary Public in and for Knox County, Tennessee.

WENDY S. O'NEAL
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF KNOX

Wendy S. O'Neal
NOTARY PUBLIC

My commission expires 3/31/18.

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

October 1, 2014

Jerry W. Taylor, Esq.
Stites & Harbison, PLLC
SunTrust Plaza, Suite 800
401 Commerce Street
Nashville, TN 37219

RE: Certificate of Need Application -- University of Tennessee Medical Center (UTMC) - CN1409-042

Dear Mr. Taylor:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need for the expansion of the NICU, ICU and Medical/Surgical services through a combination of new construction and renovation of 55,302 total square feet. The project includes the expansion and renovation of the NICU, a new addition to the ICU, a new addition to convert non-inpatient care space to inpatient rooms and the addition of forty-four (44) beds. Of the forty-four (44) new beds requested, twenty-eight (28) will be allocated as Medical/Surgical beds and sixteen (16) as ICU beds. The expansion project will be on the main campus of UTMC, located at 1924 Alcoa Highway, Knoxville (Knox County), Tennessee. Project cost is $26,292,001.00.

Please be advised that your application is now considered to be complete by this office. Your application is being forwarded to the Tennessee Department of Health and/or its representative for review.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on October 1, 2014. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on December 17, 2014.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill

Melanie M. Hill
Executive Director

MMH:mab

cc: Trent Sansing, CON Director, Division of Health Statistics

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill MMH/MF
Executive Director

DATE: October 1, 2014

RE: Certificate of Need Application
University of Tennessee Medical Center (UTMC) - CN1409-042

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on October 1, 2014 and end on December 1, 2014.

Should there be any questions regarding this application or the review cycle, please contact this office.

MMH:mab

Enclosure

cc: Jerry W. Taylor, Esq.

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Knoxville News Sentinel, which is a newspaper of general circulation in Knox County, Tennessee, on or before September 10, 2014 for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.,* and the Rules of the Health Services and Development Agency, that The University of Tennessee Medical Center (UTMC), owned and managed by University Health System, Inc., a Tennessee not-for-profit corporation, intends to file an application for a Certificate of Need for: (1) the expansion and renovation of its Neonatal Intensive Care Unit (NICU) consisting of approximately 9,758 square feet of new construction and 15,432 square feet of renovated space; (2) the addition of approximately 16,850 square feet of new space and renovation of approximately 1,262 square feet of existing space, which will house a new addition to the Intensive Care Unit (ICU); (3) the renovation of approximately 12,000 square feet of existing space to convert it from non-inpatient care space to inpatient rooms; and (4) the addition of 44 acute care beds to its license. Of the 44 requested beds, 28 are anticipated to be allocated as general medical surgical beds, and 16 as ICU beds. UTMC is located at 1924 Alcoa Highway, Knoxville, Knox County, Tennessee, and is licensed as a general acute care hospital by the Tennessee Board for Licensing Health Care Facilities. No changes in services or major medical equipment are involved in this project. The estimated project cost is not to exceed $27,000,000.00.

The anticipated date of filing the application is September 15, 2014.

The contact person for this project is Jerry W. Taylor, Attorney, who may be reached at: Stites & Harbison, PLLC, SunTrust Plaza Suite 800, 401 Commerce Street, Nashville, Tennessee, 37219, 615-782-2228, jerry.taylor@stites.com.

Signature

9-10-14
Date

==========

The published Letter of Intent contains the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

==========

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

September 22, 2014

Jerry W. Taylor, Attorney
Stites & Harbison, PLLC
400 Commerce Street, Suite 800
Nashville, TN 37219

RE: Certificate of Need Application CN1409-042
University of Tennessee Medical Center

Dear Mr. Taylor:

This will acknowledge our September 15, 2014 receipt of your application for a Certificate of Need for the expansion of the NICU, ICU and Med/Surg services of the hospital through a combination of new construction and renovation of 55,302 total square feet. The project includes the expansion renovation of the NICU, a new addition to the ICU, a new addition to convert from non-inpatient care space to inpatient rooms and the addition of 44 beds including the construction of a new ICU addition to the ICU and the addition of 44 licensed beds – 28 to be allocated as Medical/Surgical beds and 16 as designated ICU beds. The expansion project will be on the main campus of UTMC, located at 1924 Alcoa Highway, Knoxville (Knox County), Tennessee. Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 1:00 p.m., September 29, 2014. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

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1. **Section B. Project Description, Item I (Executive Summary).**

   The executive summary is noted. Under the section heading Existing Resources, please include a brief description of the project's impact on the other hospitals in the twenty-one (21) county service area.

2. **Section B. Project Description, Item II.A.**

   The square footage and cost per square footage chart is noted. Please revise the chart by providing amounts at the bottom of the chart in the appropriate columns and submit a replacement page 12 with your response.

   Please also complete the table below to identify uses of existing areas that may be impacted by the project.

Service	Floor	Description of proposed Changes (# licensed beds before/after)	Use of Space Currently	Future Location of Displaced Activities (as applicable)	Total Square Feet of New Construction or renovation Proposed
ICU	3				

3. **Section B, Project Description, Item II.B (bed complement changes)**

The proposed addition of 44 licensed beds resulting in an increase from 581 to 625 total licensed beds is noted. Review of Schedule F of the applicant's 2012 JAR revealed 315 Med/Surg beds of 534 total staffed beds in 2012 increasing to 325 Med/Surg beds of 546 total staffed beds in 2013. There are 390 staffed Med/Surg beds shown on the Bed Complement table on page 4. Please briefly describe the changes in staffed Med/Surg beds leading to the significant increase in staffed beds from 2013 to present (65 additional set up and staffed beds).

4. **Section B. Project Description, Item B. – Changes to Bed Complement**

The bed complement data chart reflects 581 licensed and 549 total staffed beds. What percentages of beds are private and semi-private – before and after the project?

Please also include a description of how this project relates to Phase 1 of renovation to the NICU completed in 2007 (see pages 10 and 26).

5. **Section C, Need. Item 1 (Project Specific Criteria)**

Acute Care Bed Need, Item 1:
The applicant's acknowledgement of the 1,250 acute care bed surplus in the PSA is noted. Review of the results revealed no estimate as to a surplus or shortage for Fentress County, and a service area population that is approximately 100,000 residents higher using updated TDH population statistics. Do any of these factors significantly affect the surplus for CY2014 in the PSA?

The number of staffed Med/Surg beds shown by unit in the attachment (C, Need, Item 1 -Chart 2) totals to 332 beds compared to 325 staffed beds in the 2013 JAR. As a result, is the occupancy slightly understated in the table? Please clarify.

Please briefly describe the acuity levels in the table showing historical/projected ED visits on page 20.

UTMC'S role as an academic medical center is noted. What was the growth in the physician residents from 2012 to present as related to the increase in patient caseloads at the hospital during the period?

The description of the applicant's use of the Poisson Probability bed need formula as a way to predict UTMC patient caseloads is noted. What sources from medical literature are available for additional insight into the model? What is the applicant's experience in using the model in terms of the accuracy/reliability of its projections in prior projects?

Acute Care Bed Need, Item 2.c:
The request for special consideration is noted. What illustrations or visuals discussed in any other sections does the applicant wish to cite as references such that specific metrics can be appreciated in this regard?

Construction, Renovation, Item 3.a

The items impacting demand for the proposed project are noted. Please include a brief recap of the increases in bed occupancy, lack of available beds to accept referrals, etc., as it pertains to this question.

The applicant states that the previous Phase 1 of renovation to the NICU was completed in 2007 and this proposal is Phase 2 for new construction of an addition to the NICU. The CON reference does not appear to be included with UTMC's list in the discussion provided on page 27 and 28 of the application. Please clarify.

If the proposal is approved, it appears that there may be approximately 10 years between completion of Phase 1 and Phase 2. What impact, if any, does the interval have to keeping on track with UTMC's long range, multiple level construction activities focusing on physical plant improvement, modernization and expanded capacity?

6. Section C, Need, Item 5

The identification & discussion of the utilization for each hospital in the service area is noted in attachment C, Need, 5(1). The 136,604 inpatient days for UTMC differ from the 140,304 days in the Historical Data Chart (same amount in applicant's 2012 JAR). As a result, occupancy appears to be understated. Please clarify.

Please add a column to the attachment that shows the current number of licensed beds by TDH for each facility (please use TDH website to verify or applicant's toolbox link on the HSDA website). What changes, if any, have occurred to the licensed beds from what was reported in the 2012 JAR and the current status?

Please also complete the table below showing the trend in utilization from 2010-2012.

Service Area Historical Utilization

Facility	Licensed Beds	2010 Patient Days	2011 Patient Days	2012 patient Days	'10-'12 % Change
21 County PSA					
UTMC					
UTMC as a % of All Hospitals					

7. **Section C., Need, Item 6.**

The utilization projections are noted. The applicant notes in the bed complement table on page 4 that the build out approved in CN0912-056AE will be completed in November 2014 which will open up another 32 Med/Surg beds. As a result, it appears the service's staffed beds will increase from 390 to 422 beds on or about December 2014. However, the projected utilization appears to be based on 342 beds in CY2014 and only 402 beds in Year 1. Please clarify. If possible, please also add projected utilization for CY2015 to further illustrate the increase in the utilization of the service's bed complement.

To help summarize the applicant's historical and projected utilization, please complete the table below.

Service	2011	2012	2013	2014	Year 1	Year 2
Med/Surg Beds						
Patient Days						
Occupancy						
ICU Beds						
Patient Days						
Occupancy						
UTMC Total Beds	581	581	581	581	625	
Patient Days						
Occupancy						

Based on the tables provided, there was a 4% increase in Med/Surg patient days from 2013 to 2014 (without observation days) and a decrease in the ICU's occupancy. As such, please summarize the rationale used to determine how many additional beds by service where needed to support the projected utilization levels of the project.

Also, please discuss the planning timeframe the applicant is using in implementing the additional 28 bed Med/Surg and 16 bed ICU capacity.

8. **Section C, Economic Feasibility, Item 1**

The documentation from a licensed architect or construction professional is noted, including the floor plans of the project provided under separate cover. However, please include a general description of the project as an addendum or attachment to the project to reflect the work to be performed discussed in detail in Section B of the application.

Please also provide a comparison to the construction costs documented by HSDA for the 2011 to 2013 period for similar hospital projects.

9. **Section C., Economic Feasibility, Item 4**

Historical Data Chart - the chart is noted. Comparison of the net revenue amount for 2013 in the chart to the applicant's 2013 JAR revealed a difference of approximately $4 million. Comparison to the net revenue in the Consolidated Statement in the attachments revealed a difference of approximately 2 million for the period. Please clarify the reasons for the differences between these sources.

Although gross revenue increase over the period by an average of approximately 12.3% per year, net revenue winds up decreasing based on a $3.6 million increase in contractual adjustments from 2011 to 2013. Briefly describe the developments that account for the decline in net revenues as reflected in the chart.

Total Operating expenses in the Historical Data Chart for 2013 appear to be approximately $15 million lower than what is reflected in the financial statements for the period. As a result, net operating income after capital expenditures appears to be overstated. Please explain.

Projected Data Chart –

The charts for both the Med/Surg and ICU services show salaries and wages based on the staffing discussed on page 44 of the application - approximately 41 Med/Surg full time equivalents and 49 ICU full time equivalents. Please describe the methodology used to determine the salary and wage amounts identified in the chart for the first year of the project.

In light of the NOI loss of -$2,263,663 for 2013 shown in the Historical Data Chart (after capital expenditures), please discuss the project's impact to the financial performance of the hospital as a whole for the first full year following completion of the project.

10. **Section C, Economic Feasibility. Item 9**

Based on review of gross revenues in the applicant's 2013 JAR, the Medicare and TennCare/Medicaid payor mix equates to approximately 55% and 8.5%, respectively in lieu of the amounts identified by the applicant in the response. Please clarify the payor mix. If in error, please provide a replacement page with your response. *Note: amounts identified in JAR for hospital: Medicare-$1,182,975,000; Medicaid/TennCare/Cover TN - $179,972,000 and $2,145,240,680*

11. **Section C, Orderly Development, Item 4**

Please complete the table below highlighting the growth in the physician medical staff that may result, in large part, from implementation of this project.

Medical Specialty	#2013 JAR	current	Year 1
Surgery			
OB/GYN			
Internal Medicine			
Other			
Total			

12. Section C, Orderly Development, Item 3

The staffing pattern is noted. The applicant states that it matches that of existing bed units of equivalent bed count. As such, it appears that total estimated staffing of the Med/Surg service and the ICU services may total to approximately 571 FTEs and 294 FTEs, respectively, using the applicant's methodology. In terms of cost, both services appear to account for approximately 65% UTMC's total salary and wage cost reflected in the Historical Data Chart for 2013. Is the methodology used by the applicant consistent with these estimates? Please confirm.

13. Section C., Orderly Development, Item 7.

The Joint Commission accreditation award effective September 2011 is noted. However, review of the award letter attached to the application and the TDH licensed facilities link on the HSDA toolkit, revealed that the accreditation will expire on September 24, 2014 before the application can be heard. Please explain the status of UTMC's accreditation at present.

Review of the TDH licensed facility report also revealed the last survey by TDH was on August 20, 2008. If a more recent survey exists, please provide a copy of the survey (with plan of correction) and a copy of the acceptance letter by the Department of Health, as applicable.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is Thursday, November 19, 2014. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ɔ 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported

to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please contact this office.

Sincerely,

Jeff Grimm
Health Services Development Agency Examiner

ORIGINAL-SUPPLEMENTAL-1

University of Tennessee Medical Center
CN1409-042

SUPPLEMENTAL RESPONSES

CERTIFICATE OF NEED APPLICATION

FOR

UNIVERSITY OF TENNESSEE MEDICAL CENTER

Hospital Expansion and Renovation, and the Addition of 44 Acute Care Beds

Knox County, Tennessee

Project No. CN1409-042

September 29, 2014

Contact Person:

Jerry W. Taylor, Esq.
Stites & Harbison, PLLC
401 Commerce Street, Suite 800
Nashville, Tennessee 37219
615-782-2228

1. **Section B. Project Description, Item I (Executive Summary).**

   The executive summary is noted. Under the section heading Existing Resources, please include a brief description of the project's impact on the other hospitals in the twenty-one (21) county service area.

   The following is an addition to the "Existing Resources" section of the Executive Summary, on page 8 of the application.

   Existing Resources

   This project should have no significant negative impact on existing hospitals in the service area. UTMC is a regional referral hospital for the 21 county service area and accordingly, routinely receives patient referrals from these hospitals whenever they determine that the patient in their facility could benefit from a higher level of care or is in need of a unique medical service only available at UTMC. The UTMC is not considered a feeder hospital for these other facilities in the region and rarely transfers a patient to another hospital in the 21 county service area unless requested by the patient or for one of a few services not available at UTMC (example being psychiatric care not available at UTMC).

   In recent years due to capacity issues, UTMC has been forced to decline or delay acceptance of requested patient transfers from hospital providers in the 21 county service area. Unfortunately, when this occurs the outlying facility finds itself in a situation of providing care to a patient for a medical condition for which it is ill equipped from a medical expertise or staffing/facility standpoint. In these cases, UTMC Specialist Physicians often consult with the local medical provider to offer suggestions and alternatives in care. In many cases the best solution is to seek another regional referral hospital to accept the patient and provide the needed medical services, usually at a great distance from the patient's home and away from friends and family

   Given the frequency in which capacity issues are encountered at UTMC and the negative impact of that on hospital providers in the service area, UTMC believes that most of the medical providers in the 21 county service area will benefit from the additional beds at UTMC and the increased capacity to accept those patients requiring the higher level or unique services offered at the regional referral center.

2. **Section B. Project Description, Item II.A.**

   The square footage and cost per square footage chart is noted. Please revise the chart by providing amounts at the bottom of the chart in the appropriate columns and submit a replacement page 12 with your response.

   A revised Square Footage and Cost Per Square Foot Chart is attached following this response.

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
NICU	3rd Floor	26,851	NA	3rd Floor	15,432	9,758	25,190	$200	$336.43	$6,369,256
New ICU	NA	NA	NA	4th Floor	1,262	16,850	18,112	$200.10	$345.74	$6,078,248
6 South	NA	NA	NA	6 South	12,000	.	12,000	$298.67		$3,584,000
B. Unit/Depart. GSF Sub-Total										
C. Mechanical/ Electrical GSF	Included above									
D. Circulation /Structure GSF	Included above									
E. Total GSF					28,694	26,608	55,302	$241.27	$342.32	$16,031,504

Please also complete the table below to identify uses of existing areas that may be impacted by the project.

Service	Floor	Description of proposed Changes (# licensed beds before/after)	Use of Space Currently	Future Location of Displaced Activities (as applicable)	Total Square Feet of New Construction or renovation Proposed
NICU	3	Addition; larger space; walled rooms (67/67)	N/A. New space	N/A. New space	25,190 s.f. (new & renovation)
ICU	4	New ICU (80/96)	N/A. New space	N/A. New space	18,112 s.f. (new & renovation)
Med-Surg	6	Convert physician clinic space to inpatient wing (422/450)	Physician Clinics	MOB	12,000 s.f. (renovation)

3. **Section B, Project Description, Item II.B (bed complement changes)**

The proposed addition of 44 licensed beds resulting in an increase from 581 to 625 total licensed beds is noted. Review of Schedule F of the applicant's 2012 JAR revealed 315 Med/Surg beds of 534 total staffed beds in 2012 increasing to 325 Med/Surg beds of 546 total staffed beds in 2013. There are 390 staffed Med/Surg beds shown on the Bed Complement table on page 4. Please briefly describe the changes in staffed Med/Surg beds leading to the significant increase in staffed beds from 2013 to present (65 additional set up and staffed beds).

The change in bed complement as described above is due solely to the formatting of the JAR data request for Schedule F and the format of the HSDA Bed Complement Data form. The JAR Schedule F has a separate line breakout for reporting OB/GYN and Orthopedic staffed bed numbers. This was reported by UTMC in the 2013 JAR as 30 staffed beds in each category, a total of 60 staffed beds. When completing the HSDA application, there is no separate breakout for either OB/GYN or Orthopedic staffed beds, so the 60 staffed beds in these units were combined in the reported Medical/Surgical category. In addition, we have brought 5 additional beds back on-line in space that had been previously vacated. This explains the variance between the JAR reported data of 325 medical/surgical beds and the 390 beds as shown on the bed complement data form.

4. **Section B. Project Description, Item B. – Changes to Bed Complement**

The bed complement data chart reflects 581 licensed and 549 total staffed beds. What percentages of beds are private and semi-private – before and after the project?

Please see the table below.

Clinical Area	Current Licensed Beds Private	Current Licensed Beds Semi-Private	Total
Medical - Surgical	422		422*
Obstetrical	12		12
ICCU/CCU	80		80
Neonatal	23	44*	67
Total	537	44	581
% of Total	92.4%	7.6%	
Clinical Area	**Proposed Licensed Beds Private**	**Proposed Licensed Beds Semi-Private**	**Total**
Medical-Surgical	450		450
Obstetrical	12		12
ICCU/CCU	96		96
Neonatal	49	18**	67
Total	607	18	625
% of Total	97%	3%	

* 18 of these beds are in 9 neonatal "twin rooms" intended for use by neonatal twins. The other 26 are neonatal beds in the open floor unit.

** The 18 neonatal twin rooms will be retained.

Please also include a description of how this project relates to Phase 1 of renovation to the NICU completed in 2007 (see pages 10 and 26).

This application includes Phase II of the NICU expansion project. Phase I was completed in 2007. Prior to that expansion and renovation, all but 18 of the 67 licensed NICU beds were in an open floor model (no dividing walls between the beds). Phase I was internal renovation and expansion only, and put 23 of the beds formerly on the "open floor" unit into separately walled private rooms. That project did not require a CON because no new beds were added, and the total cost was below $5 million.

Phase II will put the remaining 26 open floor NICU beds in separately walled rooms. (There will still be at total of 18 NICU beds in 9 "twin rooms" that are used for twin births). There will be no more open floor room beds. Since building codes have changed since the last NICU renovation to require more square footage per bed, it is necessary to build an addition out the side of the current building on the 3rd floor of the North Pavilion

to extend out over the roof of the 2nd floor. This will complete the renovation/expansion of the NICU. No new NICU beds are being requested.

5. **Section C, Need. Item 1 (Project Specific Criteria)**

Acute Care Bed Need, Item 1:
The applicant's acknowledgement of the 1,250 acute care bed surplus in the PSA is noted. Review of the results revealed no estimate as to a surplus or shortage for Fentress County, and a service area population that is approximately 100,000 residents higher using updated TDH population statistics. Do any of these factors significantly affect the surplus for CY2014 in the PSA?

The applicant does not know the reason Fentress County is not included in the Acute Bed Need calculations. Whether that omission and/or the population discrepancy referenced has any significant impact on the area wide bed surplus would be speculation. Even if it were to increase or decrease the bed surplus, that has no bearing on UTMC's need for additional capacity.

There is one hospital in Fentress County, Jamestown Regional Medical Center, which has 85 licensed beds. According to the DOH, it had a licensed average occupancy of 17.5% in 2012, so obviously there are beds available at that facility. But Jamestown Regional is located approximately 104 miles and 1 hour, 45 minutes' drive time from UTMC. It is unlikely there would be any transfers from UTMC to that facility. The calculated bed surplus in the service area has no impact on the need for additional beds at UTMC.

The number of staffed Med/Surg beds shown by unit in the attachment (C, Need, Item 1 -Chart 2) totals to 332 beds compared to 325 staffed beds in the 2013 JAR. As a result, is the occupancy slightly understated in the table? Please clarify.

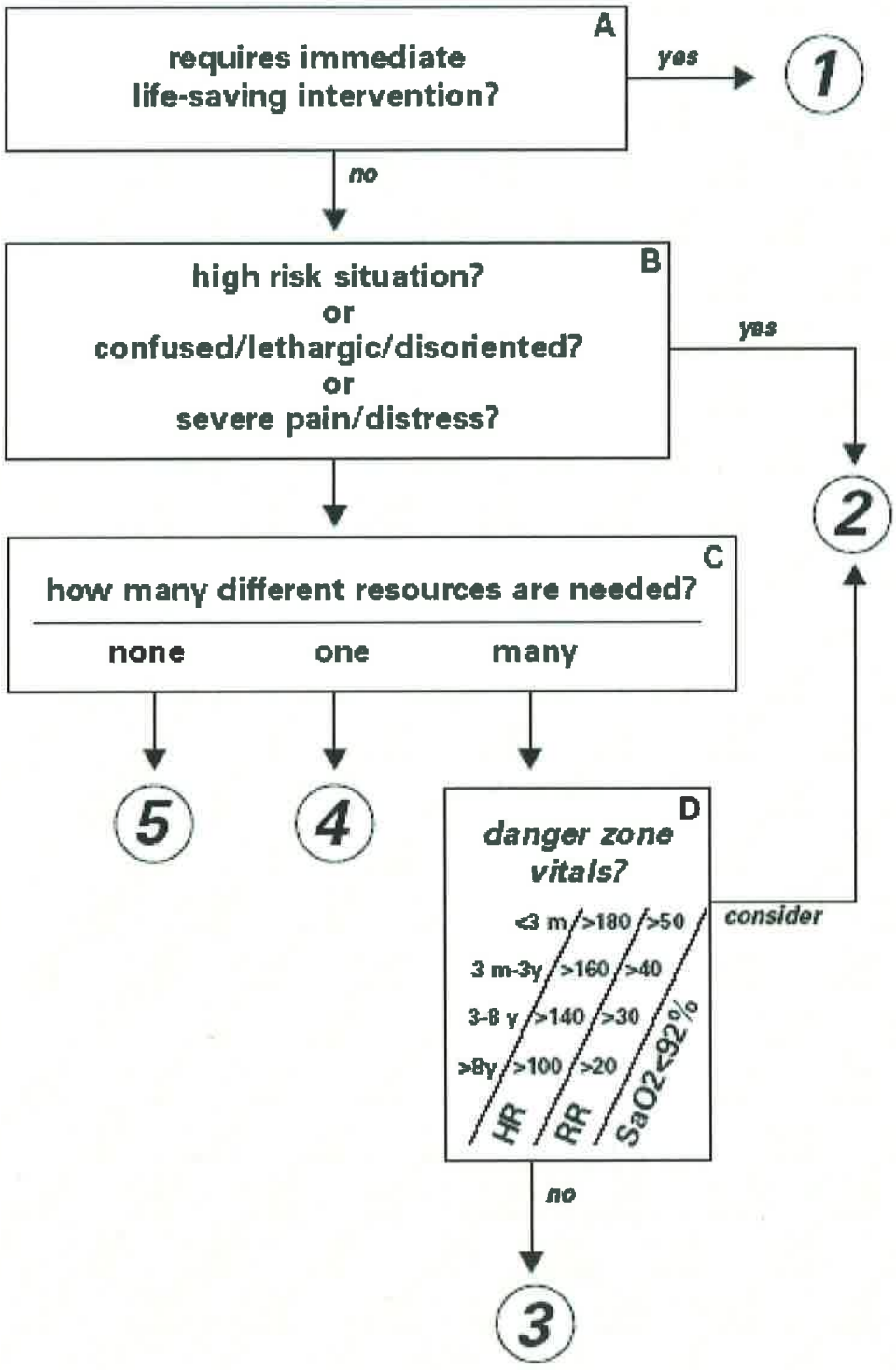
The number of staffed beds reflected on the JAR is a snapshot as of the end of the reporting period. Throughout any given year, the number of staffed beds may fluctuate as some beds have to be closed temporarily due to minor renovations and relocations of beds within the facility, and as bed designations are changed to meet the most pressing needs. The number of staffed med-surg beds and the resulting occupancies reflected on the referenced chart are correct.

Please briefly describe the acuity levels in the table showing historical/projected ED visits on page 20.

UTMC categorizes patient acuity in a five tier system from the Emergency Severity Index. This system is based on the latest medical evidence. Acuity level 1 are patients that present that need immediate medical intervention, examples include: cardiac arrest, respiratory arrest, or unstable trauma or stroke patient. Level 2 acuity are patients that need urgent medical intervention, within 30 minutes of arrival examples include: a patient that is hypertensive with symptoms, chest pain, unstable vital signs, severe abdominal patient with intractable vomiting. Level 3 patients need medical intervention within an hour, examples include: kidney stone, abdominal pain, stable vaginal bleeding, stable fracture. Level 4 patients are patients that could be treated in other environments such as an urgent care or primary care physician. Level 5 patients are those that need medication refill or medical screening exam. Attached following this response is the algorithm utilized in determining patient acuity.

SUPPLEMENTAL- 1

September 29, 2014
11:46am



UTMC'S role as an academic medical center is noted. What was the growth in the physician residents from 2012 to present as related to the increase in patient caseloads at the hospital during the period?

In the 2012-2013 academic year, there were 200 medical and dental residents at the University of Tennessee Medical Center. In 2013-2014 that number increased to 210 and for the 2014-2015 academic year, the total number of medical and dental residents will increase again to 215. These additional residents have been primarily in medicine, surgery, and oral maxillofacial surgery and would correspond with the increased demand in acute care, critical care, and trauma.

The description of the applicant's use of the Poisson Probability bed need formula as a way to predict UTMC patient caseloads is noted. What sources from medical literature are available for additional insight into the model? What is the applicant's experience in using the model in terms of the accuracy/reliability of its projections in prior projects?

Due to its statistical foundation, the Poisson Probability bed need formula is cited more often in industrial engineering and operations research literature than in medical literature. It is a much more sophisticated methodology than simply dividing projected average daily census (ADC) by a target occupancy rate (e.g., 70% or 80%). This occupancy approach depends upon a hospital-wide midnight census which does not account for daily admissions and discharges, nor does it allow for any variability in the size of the census. For example, a 500 bed hospital operating at 70% occupancy will have an average of 150 empty beds throughout the year (500 x 30% = 150). These 150 empty beds are equivalent to the size of an entire community hospital, and the facility will not operate efficiently.

At the other extreme are very complicated regression models and simulation models which require weekly or daily census data by individual nursing unit. These models can account for real time patient fluctuations and can be used to project staffing levels for the following week at the nursing unit level. However, the detailed inputs do not make them practical for health planning purposes, especially across a region or entire state.

As compared to regression and simulation models, the Poisson model requires only admissions and length of stay data to estimate optimal bed requirements. In fact, as presented in the original CON application, it can be simplified even further and calculated on ADC alone. (Annual Admissions x Average Length of Stay = Patient Days; Patient Days ÷ 365 = ADC).

Although UTMC has not used the Poisson model before, several state CON agencies, including Tennessee, use some variation of Poisson. A web search found a split in the use of the Poisson and occupancy approaches among ten states in their state health plans and/or bed need regulations. Five states use Poisson probabilities exclusively or in combination with targeted occupancies – Tennessee, Oregon, Mississippi, New Hampshire and Virginia. Five other states use targeted occupancies only – Alaska, Georgia, Maryland, New York and North Carolina. Compared to bed need projection methodologies used by the other states which use Poisson at 99% probability, UTMC's

projections using the Poisson probability method at 90% probability not only conform to reasonable health planning guidelines but also appear conservative.

Acute Care Bed Need, Item 2.c:
The request for special consideration is noted. What illustrations or visuals discussed in any other sections does the applicant wish to cite as references such that specific metrics can be appreciated in this regard?

In accordance with section 2(c) of the Acute Care Bed Need Services standards, "special consideration" should be afforded this application for the following reasons:

UTMC is a Specialty Health Service:

UTMC provides sub-specialty level services that are not provided by any other hospital in the 21 county service area. Its specialty services include:

- Area's only Academic Medical Center
- Area's only Level I Trauma Center
- Renal Transplant Center
- Regional Perinatal Center (Level II and III NICU)
- Pediatric Heart Program
- Hemophilia Center
- Adult Cystic Fibrosis Center
- LIFESTAR Aeromedical Program

The provision of these specialized services result in UTMC having a significantly higher Medicare Case Mix Index than the national average. Case Mix Index is a relative measure of patient acuity. As of August 31, 2014, UTMC has a Medicare Case Mix Index of 2.00. The national average Medicaid Case Mix Index is 1.52 based on 2013 data. Having such a high CMI value reflects the clinical complexity and resources needed for the patients cared for by UTMC, and further demonstrates the ability of UTMC to provide the highest level of care possible to the most critically ill and injured patients.

UTMC is a Tertiary Care Regional Referral Hospital

Significant numbers of referrals and admissions are received from the defined 21 county service area, and beyond. The following county of residence information is reported in the 2013 JAR:

Total UTMC Discharges:	24,958

Area:	No. of Discharges:	% of Total:
Knox Co.	9,316	37.3%
Contiguous counties (8)	8,352	33.5%
Non-contiguous service area counties (12)	5,396	21.6%
Outside service area	1,894	7.6%
Total:	24,958	100%

The admissions (discharges) pattern confirms UTMC's role as a tertiary regional referral hospital. Almost one-third (29.2%) of UTMC's patients reside outside of the home county and all contiguous counties. Another not-insignificant number of patients come from even beyond the 21 county service area.

Construction, Renovation, Item 3.a

The items impacting demand for the proposed project are noted. Please include a brief recap of the increases in bed occupancy, lack of available beds to accept referrals, etc., as it pertains to this question.

NICU Expansion: Of the 67 licensed NICU beds, 26 of those are currently housed on an open floor which has no dividing walls between the beds. There is also no external natural lighting available on this unit. While the highest level of care is obviously still provided on this unit, the private rooms, larger per bed space, and external lighting are all significant improvements in comfort and privacy for the infants and their families. There is no space available within the walls to provide these improvements, so the proposed addition is necessary.

This is the second phase of renovation to the NICU. The first phase was completed in February, 2007 and consisted of essentially the same changes – converting a multi-basinet, open floor unit to separately walled, mostly single rooms. This proposed second phase will complete the renovation and modernization of the 67 bed NICU. No beds are being added to the NICU, so no discussion of bed need or utilization is necessary.

ICU Expansion/Addition: UTMC currently has 80 ICU/CCU beds (75 adult and 5 pediatric). Occupancy on the ICU beds runs extremely high, and additional capacity is needed. UTMC intends to allocate 16 of the requested 44 additional acute care beds to ICU use. There is no physical space within the walls to house the beds, so the addition is necessary. The proposed addition of the NICU will extend out over what is now the roof of the 2nd floor, and the proposed ICU addition will be constructed on top of the NICU addition.

Considerations justifying the need for additional ICU beds, which are further discussed in more detailed throughout the application, include the following:

- In 2013, UTMC declined to accept for transfer 144 patients requiring adult intensive care treatment. In 2014, that number increased to 229 patients from January - August. If this continues that number could reach 344 by the end of the year.

- Of the patients declined transfer to UTMC, 16.2% of the patients this year were patients suffering a neurological injury/illness, and 40.6% suffered from an acute medical illness that exceeded the ability of the hospital currently providing care, necessitating transfer to a facility with more resources in terms of equipment, training and specialized care providers.

- As of August 31, 2014, UTMC has a Medicare Case Mix Index of 2.00. The national average Medicaid Case Mix Index is 1.52 based on 2013 data. Having such a high CMI value reflects the clinical complexity and resources needed for the patients cared for by UTMC, and further demonstrates the need for additional ICU beds.

- Due to capacity constraints and a record volume of requests for transfers to UTMC ICUs from the region, the hospital has been on critical (intensive) care hold 114 of the 243 days elapsed January through August in 2014. The result is an increase in the average number of days being on critical (intensive) care unit hold of 9 per month in 2013 to 14 per month in 2014. Thus in 2014 ICU patients were declined for transfer to UTMC's ICU roughly 47% of the time.

- Requests for ICU patient transfers tend to come in clusters particularly when UTMC is on critical (intensive) care hold. As many as 8 patients in one 24 hour period have been refused for transfer to UTMC due to all intensive care units being full to capacity. UTMC aims to maintain a goal occupancy rate of 70% - 80% to maintain maximal efficiency and effectiveness.

- August year-to-date 2014, there are multiple examples of between 10–14 patients requiring intensive care being unable to transfer to UTMC's ICU within a 3 consecutive day period. With an average ICU ALOS of 3.59 days, a 16 bed ICU would have an occupancy rate from 63% to 88%, while all other current ICUs would be running at 100% occupancy (on days the hospital is on critical (intensive) care unit hold).

The need for additional critical care beds at UTMC is also clearly evidenced by the historical utilization and occupancy of the existing critical care beds:

- As reflected on Attachment C, I, Need, 1, Chart 4 the adult critical care units occupancy rate averaged 78.3%, and exceeded 70% every month except for one. There is very little fluctuation in the occupancy – the beds are consistently highly utilized. And it is important to note that critical care beds, because they are distributed among smaller nursing units due to higher patient acuity, cannot be run at the 80% target threshold for all hospital bed types.

- As reflected on Attachment C, I, Need, 1, Chart 5 in 2013 all adult critical care units at UTMC averaged 95% or greater occupancy on 78 days during the year, and 90% or greater occupancy on 115 days during the year.

- As reflected on Attachment C, I, Need, 1, Chart 6 in 2013 the daily occupancy on all adult critical care units at UTMC exceeded 80% 183 days during the year, exceeded 85% on 104 days, exceeded 90% on 41 days, ,and exceeded 95% on 9 days.

- E.D. Hold hours increased from 92 average hold hours a day in 2009 to 235 average hold hours a day in 2014.

These occupancies are clearly unacceptable for critical care beds. By increasing adult intensive care bed capacity UTMC will be better able to serve the needs of the residents and visitors in the region.

Renovation/Conversion of 6th Floor South to Inpatient Rooms: UTMC proposes to allocate 28 of the requested 44 additional acute care beds to general medical/surgical use. These 28 new med/surg beds will be located on the 6th floor of the East Pavilion. This space is currently being used for non-inpatient care purposes. These existing uses will be relocated to existing space in a medical office building on the campus. The space will be renovated into 28 private inpatient rooms. This is a more cost effective approach than new construction, although specific cost estimates for new construction of roughly 12,000 square feet of new construction were not obtained.

The University of Tennessee Medical Center, the region's only academic medical center, serves as the regional referral center and sole Level I trauma center for a 21 county service area. The current number of medical-surgical beds is not adequate to provide care for all patients who are referred for acute care. Considerations justifying the need for additional Med-Surg beds, which are further discussed in more detailed throughout the application, include the following:

- As reflected on Attachment C, I, Need, 1, Chart 1 in 2013 the adult medical surgical occupancy rate averaged 89.1%, and exceeded 85% every month. There is very little fluctuation in the occupancy – the beds are consistently highly utilized.

- As reflected on Attachment C, I, Need, 1, Chart 2 in 2013 the 11 adult med-surg units at UTMC averaged 95% or greater occupancy 165 days during the year, and 90% or greater occupancy 232 days during the year.

- As reflected on Attachment C, I, Need, 1, Chart 3 in 2013 the adult med-surg units experienced a daily occupancy of 95% or greater occupancy 81 days during the year, and 80% or greater occupancy 325 days during the year.

Below are several additional contributing factors that necessitate additional medical-surgical, acute care beds to accommodate the current needs of the region:

- The number of referrals not accepted YTD July 2014 is 384. Of those, 229 were critical care patients, leaving 155 patients who needed an general medical surgical bed. If this trend continues there will be over 650 patients in 2014 who need the services of UTMC, but could not be served due to unavailability of beds.

- Emergency Room visits have increased from 64,500 in 2009 to over 85,000 in 2013. Over 40% of all patients who are treated in the emergency room require use of an acute care bed during the patient's stay. The lack of available beds leads to internal queuing and inefficiencies. E.D. Hold hours increased from 92 average hold hours a day in 2009 to 235 average hold hours a day in 2013.

These occupancies are clearly unacceptable for med-surg beds. By increasing adult med-surg bed capacity UTMC will be better able to serve the needs of the residents and visitors in the region.

The applicant states that the previous Phase 1 of renovation to the NICU was completed in 2007 and this proposal is Phase 2 for new construction of an addition to the NICU. The CON reference does not appear to be included with UTMC's list in the discussion provided on page 27 and 28 of the application. Please clarify.

Phase I was internal renovation and expansion only, and put 23 of the open floor unit beds into separately walled private rooms. That project did not require a CON because no new beds were added, and the total cost was below $5 million.

If the proposal is approved, it appears that there may be approximately 10 years between completion of Phase 1 and Phase 2. What impact, if any, does the interval have to keeping on track with UTMC's long range, multiple level construction activities focusing on physical plant improvement, modernization and expanded capacity?

Phase I of the renovation of NICU was completed in 2007 and was funded with a combination of hospital funds, private gift donations, and a substantial federal grant. Phase I of the renovation project did not meet the criteria or expenditure thresholds to require a CON. During the intervening years, the codes and requirements for certified and accredited neonatal intensive units changed significantly and required a major redesign of the size and scope of Phase II and the project now requires a CON. Also in the intervening years and because of the change in the size and scope of the project, additional internal funding was required and a major private gift campaign was successfully completed. At the conclusion of Phase II, the NICU will have been completely renovated and will meet all of the current codes and requirements for certification and accreditation.

6. **Section C, Need, Item 5**

The identification & discussion of the utilization for each hospital in the service area is noted in attachment C, Need, 5(1). The 136,604 inpatient days for UTMC differ from the 140,304 days in the Historical Data Chart (same amount in applicant's 2012 JAR). As a result, occupancy appears to be understated. Please clarify.

UTMC reported 140,304 Patient Days in Schedule G, Item 2 (Utilization by Major Diagnostic Categories) on its 2012 JAR. That is the same number reflected on the Historical Data Chart for 2012. The 136,304 that was taken from the DOH compilation is apparently taken from Schedule G, Item 5 (Patient Origin) which is reported in Discharge Days, rather than Patient Days.

Using the number of days reported on Schedule G, Item 2 of the JAR, the overall average licensed occupancy (not including observation days) for 2012 is 66.7%, as compared to the 64.4% reflected on the DOH data chart.

Please add a column to the attachment that shows the current number of licensed beds by TDH for each facility (please use TDH website to verify or applicant's toolbox link on the HSDA website). What changes, if any, have occurred to the licensed beds from what was reported in the 2012 JAR and the current status?

A revised table is attached following this response, which reflects the number of reported licensed beds for 2014 according to the Department of Health, Division of Health Care Facilities website. Those totals indicate an increase of 483 licensed beds from 2012-2014. The facilities showing a change in bed complement are reflected in bold type in the table. The applicant questions the accuracy of the resulting bed increase, and believes it to be a reporting or posting error. Pioneer Community Hospital in Scott County did put 25 previously inactive beds back into service in 2014 as Critical Access Hospital beds, but the applicant is not aware of any other actual net increases in beds in the service area.

Joint Annual Report of Hospitals Occupancy Rates 2012 Final & 2014 Licensed Beds

Name of Hospital	County	Licensed Beds	Staffed Beds	Inpatient Days	Licensed Beds		Staffed Beds		Licensed Beds Current *
					Days Open	Occ. Rate	Days Open	Occ. Rate	
Methodist Medical Center of Oak Ridge	Anderson	301	255	48,308	109,865	44.0	93,075	51.9	301
Ridgeview Psychiatric Hospital and Center	**Anderson**	**16**	**16**	**3,372**	**5,840**	**57.7**	**5,840**	**57.7**	**Not Listed**
Blount Memorial Hospital	Blount	304	238	51,691	110,960	46.6	86,870	59.5	304
Peninsula Hospital	**Blount**	**155**	**137**	**29,332**	**56,575**	**51.8**	**50,005**	**58.7**	**0**
Tennova Healthcare - Lafollette Medical Center	Campbell	66	66	11,429	24,090	47.4	24,090	47.4	66
Jellico Community Hospital, Inc.	Campbell	54	31	4,724	19,710	24.0	11,315	41.7	54
Claiborne County Hospital	Claiborne	85	39	7,178	31,025	23.1	14,235	50.4	85
Tennova Healthcare - Newport Medical Center	**Cocke**	**74**	**36**	**7,607**	**27,010**	**28.2**	**13,140**	**57.9**	**16**
Cumberland Medical Center	Cumberland	189	123	22,073	68,985	32.0	44,895	49.2	189
Jamestown Regional Medical Center	Fentress	85	54	5,422	31,025	17.5	19,710	27.5	85
Morristown - Hamblen Healthcare System	Hamblen	167	147	25,436	60,955	41.7	53,655	47.4	167
Lakeway Regional Hospital	Hamblen	135	65	14,064	49,275	28.5	23,725	59.3	135
Wellmont Hancock County Hospital	Hancock	10	10	1,199	3,650	32.8	3,650	32.8	10
Wellmont Hawkins County Memorial Hospital	Hawkins	50	46	3,530	18,250	19.3	16,790	21.0	50
Tennova Healthcare - Jefferson Memorial Hospital	Jefferson	58	58	8,565	21,170	40.5	21,170	40.5	58
Fort Sanders Regional Medical Center	Knox	517	378	86,156	188,705	45.7	137,970	62.4	517
Tennova Healthcare	**Knox**	**111**	**243**	**74,903**	**40,515**	**184.9**	**88,695**	**84.5**	**903**
University of Tennessee Memorial Hospital	Knox	581	534	136,604	212,065	64.4	194,910	70.1	581
East Tennessee Children's Hospital	Knox	152	152	40,530	55,480	73.1	55,480	73.1	152
Parkwest Medical Center	**Knox**	**307**	**297**	**75,068**	**112,055**	**67.0**	**108,405**	**69.2**	**462**
Mercy Medical Center West	Knox	101	101	16,853	36,865	45.7	36,865	45.7	0
North Knoxville Medical Center	Knox	108	72	15,128	39,420	38.4	26,280	57.6	0
Select Specialty Hospital - Knoxville	Knox	35	35	10,153	12,775	79.5	12,775	79.5	35
Select Specialty Hospital - North Knoxville	Knox	33	33	9,127	12,045	75.8	12,045	75.8	33
Fort Loudoun Medical Center	Loudon	50	30	6,195	18,250	33.9	10,950	56.6	50
Woods Memorial Hospital	**McMinn**	**72**	**48**	**7,526**	**26,280**	**28.6**	**17,520**	**43.0**	**0**
Athens Regional Medical Center	**McMinn**	**118**	**63**	**8,366**	**43,070**	**19.4**	**22,995**	**36.4**	**190**
Sweetwater Hospital Association	Monroe	59	59	10,251	21,535	47.6	21,535	47.6	59
Roane Medical Center	**Roane**	**105**	**36**	**6,620**	**38,325**	**17.3**	**13,140**	**50.4**	**54**
Pioneer Community Hospital	**Scott**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**25**
LeConte Medical Center	Sevier	79	69	13,269	28,835	46.0	25,185	52.7	79
Service Area Total/Average		**4,177**		760,679		46.7%		53.6%	**4,660**

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics
* Current Licensed Beds from Health Care Facilities Licensed Facilities website.

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September 29, 2014
11:46am

Please also complete the table below showing the trend in utilization from 2010-2012.

Service Area Historical Utilization

Facility	Licensed Beds (2012)	2010 Patient Days	2011 Patient Days	2012 patient Days	'10-'12 % Change
21 County PSA	4,177	829,367	821,813	760,679	-8.3%
UTMC	581	137,257	137,141	140,304	+2.2%
UTMC as a % of All Hospitals	14%	16.5%	16.7%	18.4%	+1.9%

Area-wide, inpatient days decreased by 8.3% from 2010-2014. During this same period of time, UTMC's inpatient days increased by 2.2%. During this same time, UTMC's inpatient days as a percentage of total area-wide inpatient days, grew each year for a total increase of 1.9%. And this growth does not take into account observation days, which have grown significantly at UTMC.

7. **Section C., Need, Item 6.**

The utilization projections are noted. The applicant notes in the bed complement table on page 4 that the build out approved in CN0912-056AE will be completed in November 2014 which will open up another 32 Med/Surg beds. As a result, it appears the service's staffed beds will increase from 390 to 422 beds on or about December 2014. However, the projected utilization appears to be based on 342 beds in CY2014 and only 402 beds in Year 1. Please clarify. If possible, please also add projected utilization for CY2015 to further illustrate the increase in the utilization of the service's bed complement.

The projected utilization is for staffed med-surg beds only, not total hospital staffed beds. So the current staffed med-surg bed total of 342 will increase by 60 beds to 402 in Year 1 (28 requested new beds + 32 beds to be opened in the Heart Hospital in November, 2014).

The column for 2015 projected utilization has been added to the table below.

To help summarize the applicant's historical and projected utilization, please complete the table below.

Service	2011	2012	2013	2014	2015 (Projected)	Year 1	Year 2
Med/Surg Beds	312	327	319	342	374	402	402
Patient Days	89,201	98,740	103,976	116,220	122,270	127,564	128,840
Occupancy	78.3%	82.7%	89.3%	93.1%	89.6%	86.9%	87.8%8

ICU Beds (Adult)	76	75	75	75	75	91	91
Patient Days	22,680	21,687	21,563	22,346	22,793	27,241	27,606
Occupancy	81.8%	79.2%	78.8%	81.6%	83.3%	82%	83.1%
UTMC Total Beds	581	581	581	581	581	625	625
Patient Days	155,583	156,827	162,214	176,342	180,837	190,641	192,548
Occupancy	73.4%	74%	76.5%	83.2%	85.3%	83.6%	84.4%

Based on the tables provided, there was a 4% increase in Med/Surg patient days from 2013 to 2014 (without observation days) and a decrease in the ICU's occupancy. As such, please summarize the rationale used to determine how many additional beds by service where needed to support the projected utilization levels of the project.

Med-surg beds: In evaluating the need for additional med-surg beds at UTMC, it is imperative to consider observations days. In many cases, it is not known whether an observation patient will in fact become an inpatient admission until 24-48 hours after the patient is put in a bed. Furthermore, whether the patient is eventually determined to be inpatient or observation patient, that patient occupies a bed. In that sense, and in determining bed utilization, occupancy, and utilization, there is no difference between and inpatient and observation patient. The only difference is the reimbursement.

Accordingly, the more accurate measurement of growth in utilization is total patient days including observation days. As reflected on the table on page 30 of the application, total med-surg patient days grew 17.7% between 2012-2014, and 11.8% between 2013-2014. Even excluding observation days, patient days grew by 10.1% between 2012-2014.

Furthermore, there is no reason to believe the increase in utilization will drop off in the future. Emergency Room visits have increased from 64,500 in 2009 to over 85,000 in 2013. Over 40% of all patients who are treated in the emergency room require use of an acute care bed during the patient's stay.

Another factor contributing to the need for addition beds relates to UTMC's position as the only academic medical center in the region. UTMC has a total of 210 Residents and Fellows (physicians in advanced training seeing patients every day and fulfilling its commitment as a teaching hospital and training the next generation of physicians). 27 of these Residents/Fellows are supported through funding directly from UTMC.

In order to maintain accreditation for these training programs certain patient volumes and encounters are required. As medical schools are encouraged to increase enrollments to meet the projected physician shortages, additional resident/fellow positions will be required at teaching hospitals/academic medical centers. This will also contribute to the need for additional beds in the future. The need for additional teaching beds, whether

they be medical surgical or critical care, cannot be quantified, but it is another consideration in the rationale that additional beds are needed.

ICU beds: As reflected in the table on page 31 of the application, there was 3.6% increase in ICU patient days between 2013-2014. There was a 3% increase in ICU patient days between 2012-2014. There was a 0.5% decline in ICU patient days between 2012-2013.

While a 3.6% increase over two years may seem modest in the abstract, the fact is the starting point of the occupancy increase -- 79% -- is reaching the upper limits of maximum efficiency and effectiveness for critical care beds. Critical care beds, because they are distributed among smaller nursing units due to higher patient acuity, cannot be run at the 80% target threshold for all hospital bed types.

UTMC's status as a teaching hospital, a Level I Trauma Center, and a Certified Comprehensive Stroke Center will continue to contribute to the need for the additional ICU beds and will assure continued growth in ICU admissions and patient days. As reflected in the second table on page 31 of the application, the additional beds are likewise projected to maintain occupancy in the 80% range in the first years of operation.

Also, please discuss the planning timeframe the applicant is using in implementing the additional 28 bed Med/Surg and 16 bed ICU capacity.

UTMC anticipates the construction completion and opening of the 28 bed Med/Surg unit in the First Quarter of 2016. The 16 Bed ICU capacity is forecasted to be completed and opened the Third Quarter of 2017.

8. **Section C, Economic Feasibility, Item 1**

The documentation from a licensed architect or construction professional is noted, including the floor plans of the project provided under separate cover. However, please include a general description of the project as an addendum or attachment to the project to reflect the work to be performed discussed in detail in Section B of the application.

Another letter from the project architect is attached following this response.

SUPPLEMENTAL- 1

September 29, 2014
11:46am

BARBER McMURRY
architects since 1915

September 24, 2014

Mr. Scott Castleberry
Director Facilities Planning and Construction Services
University Health System, Inc.
1924 Alcoa Highway
Knoxville, TN 37920

RE: UHS NICU Phase II
Knoxville, Tennessee
BMa Project No. 132000

Dear Mr. Castleberry:

By letter dated September 10 we verified the estimated construction-related costs of this project are reasonable, and listed the applicable building codes. In response to the question from the Project Examiner with the Health Services and Development Agency, this will confirm our understanding of the general scope of the project as follows:

1. Expansion of the Neonatal Intensive Care Unit (NICU). The NICU is located on the 3rd floor of the North Pavilion. It has 67 beds/basinets. The NICU currently consists of 26,851 square feet of space. Of this total, 15,432 square feet, an "open floor" unit (no dividing walls between bassinets) with 33 beds, will be renovated to provide support areas for the new private patient rooms. The NICU will also be expanded through a new construction addition to adjoin the current unit on the north side. This will be accomplished by building new space on what is now the roof of the 2nd floor. The new construction will consist of 9,758 square feet of separately walled, single occupancy rooms. The additional space is required in order for the entire NICU to comply with new code requirements, and to provide infants and families with adequate and comfortable space.

2. A new Intensive Care Unit (ICU) will be located on the 4th floor of the North Pavilion. This new construction addition will adjoin the current building, and will be located above the new space constructed for the NICU on the 3rd floor. It will consist of 16,850 square feet of new space. In addition, minor renovation will be required to the elevator lobby (mainly for purpose of adjoining the existing building to the newly constructed addition) which will consist of 1,262 square feet. This addition will house the 16 requested additional beds for the ICU.

3. Renovation of the 6th floor of the South Tower. This space consists of 12,000 square feet and is currently not used for inpatient care; it houses outpatient physician clinical offices. This space will be renovated and converted to general acute care bed space. The offices currently occupying the space will be relocated to a medical office building on the UTMC campus. This space will house 28 of the additional beds requested. All rooms will be single occupancy.

Please let us know if you require additional information.

Sincerely,

BarberMcMurry architects LLC

Charles V. Griffin, AIA
President

Cc: Laura Johnston, File

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SUPPLEMENTAL- 1

September 29, 2014
11:46am

Please also provide a comparison to the construction costs documented by HSDA for the 2011 to 2013 period for similar hospital projects.

The HSDA approved costs for hospital renovation and construction reflected on pages 34 and 35 of the application are actually for the period 2011-2013. The reference to 2011-2012 was a typographical error.

Replacement pages for pages 34 and 35 are attached following this response.

2. **Identify the funding sources for this project.**

   a. **Please check the applicable item(s) below and briefly summarize how the project will be financed.** ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

__ **A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;**

__ **B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;**

__ **C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.**

__ **D. Grants--Notification of intent form for grant application or notice of grant award; or**

X **E. Cash Reserves--Appropriate documentation from Chief Financial Officer.**

A letter from the Chief Financial Officer for UTMC is attached as Attachment C, II, Economic Feasibility, 2.

__ **F. Other—Identify and document funding from all other sources.**

3. **Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.**

The total estimated project cost is $26,292,001. The largest single item is the construction cost of $16,031,504, and a related contingency of $2,404,726. The reasonableness of this cost is verified by the project architect in Attachment C, II, Economic Feasibility, 1.

As reflected on the Square Footage and Cost Per Square Footage Chart, the cost for renovation range from $200 per square foot to $299 per square foot. The new construction costs range from $336 per square foot to $346 per square foot.

The renovation cost p.s.f. is slightly above the 3rd Quartile of approved CON hospital costs for applications approved 2011-2013, which is $249 p.s.f. The new

construction cost is likewise slightly above the 3rd Quartile of approved CON hospital costs for applications approved 2011-2013, which is $324 p.s.f. Part of the reason the UTMC estimated cost is higher is due to inflation, and part of it is due to the fact this construction job has challenges as far as extending out over a current roof area. This is generally more expensive that building on open ground.

The next largest cost is movable equipment at a cost of $4,359,965. No major medical equipment is involved. The only single piece of equipment is an Omnicell, which is a medication dispensing unit, which is state of the art and will be tied into patients' Electronic Health Records. All equipment purchases were negotiated at arms-length among experienced healthcare purchasers and vendors and are reasonable.

The Architectural and Engineering fees were likewise negotiated at arms-length and the professionals providing these services are experienced and well known to the management team at UTMC. These fees are reasonable.

3. **Complete Historical and Projected Data Charts on the following two pages--*Do not modify the Charts provided or submit Chart substitutions*! Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the *Proposal Only* (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).**

Attached on the pages following this response are the following:

A Historical Data Chart for UTMC.

A Projected Data Chart for the requested medical surgical beds.

A Projected Data Chart for the requested ICU beds.

9. Section C., Economic Feasibility, Item 4

Historical Data Chart **- the chart is noted. Comparison of the net revenue amount for 2013 in the chart to the applicant's 2013 JAR revealed a difference of approximately $4 million. Comparison to the net revenue in the Consolidated Statement in the attachments revealed a difference of approximately 2 million for the period. Please clarify the reasons for the differences between these sources.**

Generally speaking, the differences are due to how certain revenues are categorized on the different reports. An explanation is reflected below.

Historical Data Chart vs. JAR:

Per Historical Chart – "Net Operating Revenue" =	$628,587,587
Per JAR – "Total Revenue" =	$632,479,878

The difference is $3,892,291. This amount is the non-operating revenue.

In the JAR the non-operating revenue is included in "Total Revenue."

On the Historical Data Chart the non-operating revenue is included in "Total Other Revenue – Net."

Historical Data Chart vs. Consolidated Statement:

Comparison to net revenue in the Consolidated Statement in the attachments revealed a difference of approximately $2 million for the period.

Consolidated Total Revenue	631,443,788
Less: UHSV Total Revenue	(1,456,348)
Less: RTS Total Revenue	(1,399,853)
Equals: Medical Center Total Revenue	628,587,587
Per Historical Chart - Net Operating Revenue	628,587,587
Difference:	-

Please refer to page 32 of the Consolidated Financial Statements and Schedules. Page 32 is the consolidating schedule and shows the Medical Center Total Revenue in column 1 and the consolidated Total Revenue for all companies in Column 5. Column 5 ties to the Consolidated Statement of Operations on page 4 of the audited financials.

Although gross revenue increase over the period by an average of approximately 12.3% per year, net revenue winds up decreasing based on a $3.6 million increase in contractual adjustments from 2011 to 2013. Briefly describe the developments that account for the decline in net revenues as reflected in the chart.

Net Operating Revenue increased from 2011 to 2013.

Net Operating Income decreased from 2011 to 2013.

The decline in NOI is due to several factors. One is the increase in contractual adjustments, as noted. Another is a decrease in Other Revenue, the categories of which are itemized on the HDC. Another is an increase in Total Operating Expenses, as reflected on the HDC.

Total Operating expenses in the Historical Data Chart for 2013 appear to be approximately $15 million lower than what is reflected in the financial statements for the period. As a result, net operating income after capital expenditures appears to be overstated. Please explain.

Historical Data Chart - Total Operating Expenses	611,474,700
Historical Data Chart - Capital Expenditure - Interest	12,270,742
Total Expense	623,745,442
Consolidated Financials - Page 32,Column 1 Medical Center Total Operating Expenses	623,745,442

Please refer to page 32 of the Consolidated Financial Statements and Schedules. Page 32 is the consolidating schedule and shows the Medical Center Total Operating Expense in column 1 and the consolidated Total Operating Expenses for all companies in Column 5. Column 5 ties to the Consolidated Statement of Operations on page 4 of the audited financials.

Projected Data Chart –

The charts for both the Med/Surg and ICU services show salaries and wages based on the staffing discussed on page 44 of the application - approximately 41 Med/Surg full time equivalents and 49 ICU full time equivalents. Please describe the methodology used to determine the salary and wage amounts identified in the chart for the first year of the project.

The salary and wage amounts on the projected data charts were extrapolated from current actual direct (patient care) and indirect (support services) expenses per patient day for similar nursing units. An existing med/surg unit, with patients of comparable acuities, was used for the new med/surg projection, and an existing critical care unit was used to model the expenses for the new critical care unit.

In light of the NOI loss of -$2,263,663 for 2013 shown in the Historical Data Chart (after capital expenditures), please discuss the project's impact to the financial performance of the hospital as a whole for the first full year following completion of the project.

UHS is experiencing an increasing number of days where we cannot accept all the patients who choose to come to the Medical Center. This project helps us to address these capacity constraints.

From an accounting/financial performance perspective, UHS should experience improved results. These additional patients should be treated at a lower cost basis. While the direct costs of staffing the units with caregivers will be similar, the indirect cost will be lower on this incremental volume. For example, additional revenue cycle staff will not need to be hired for this additional volume. Lower indirect costs will improve the financial performance of the Medical Center.

10. Section C, Economic Feasibility. Item 9

Based on review of gross revenues in the applicant's 2013 JAR, the Medicare and TennCare/Medicaid payor mix equates to approximately 55% and 8.5%, respectively in lieu of the amounts identified by the applicant in the response. Please clarify the payor mix. If in error, please provide a replacement page with your response. ***Note: amounts identified in JAR for hospital: Medicare-$1,182,975,000; Medicaid/TennCare/Cover TN - $179,972,000 and $2,145,240,680***

The projected payor mix numbers in the application are believed to be accurate, and match very closely the historical experience as reflected in the 2013 JAR. The sources of the perceived discrepancy are the following:

1. The amount of Medicare gross revenue stated in the question ($549,973,563) double-counts the Medicare Managed Care revenues set forth in the JAR. The amount in Line 1.a.1 is incorporated into the amounts in Line 1.a. So, $198,141,346 was duplicated in the reviewer's number, thus increasing the Medicare mix.

2. The amount of Medicaid/TennCare/Cover TN stated in the question ($179,972,000) is not the correct amount, and the source of that number is not known to the applicant. The correct amount is $344,919,545. This caused the perceived TennCare mix to be lower than it actually was.

When the correct numbers are used, the 2013 Medicare mix was 46%, which is the projected Medicare mix stated in the application.

When the correct numbers are used, the 2013 TennCare mix was 16%. The applicant discounted the projected TennCare mix for this project down to 13%, due to the fact some relatively high TennCare admissions such as O.B. are not included in this project.

A table showing the calculations used is attached following this response.

SUPPLEMENTAL- 1

September 29, 2014
11:46am

		Total per Supp Questions		Correct Amounts
Medicare Charges per JAR				
1.a)	Medicare I/P - Total (includes managed care	549,973,563		549,973,563
1.a)	1) Medicare Managed Care - I/S	198,141,346	duplicated	
1.b)	Medicare O/P Total	434,859,915		434,859,915
	Total Medicare	1,182,974,824		984,833,478
	Total Charges	2,145,240,679		2,145,240,679
	Per 2013 JAR- Payor Percent	55.1%		45.9%
	Per CON Application Medicare Mix			46%

Medicaid/TennCare Charges per JAR		Total per Supp Questions	Correct Amounts
1. c)	Medicaid/TennCare Inpatient		218,309,727
1. d)	Medicaid/TennCare Outpatient		124,357,091
2. a)	Cover TN		2,252,636
	Total Medicaid/TnCare Charges (undetermined source)	179,972,000	344,919,454
	Total Charges	2,145,240,679	2,145,240,679
	Per 2013 JAR - Payor Percent	8.4%	16.1%
	Per CON Application TennCare mix		13%

The projected TennCare mix for this project was lowered from the historical hospital wide TennCare mix due to the fact that certain relatively high TennCare admissions such as OB are not included in this project.

11. Section C, Orderly Development, Item 4

Please complete the table below highlighting the growth in the physician medical staff that may result, in large part, from implementation of this project.

Medical Specialty	#2013 JAR	Current	Year 1
Surgery	138	145	
OB/GYN	41	40	
Internal Medicine	35	39	43.2
Other	302	302	
Total	516	526	

Medical staff physician growth is expected to be at a rate consistent with historical trends. We estimate an additional 4.2 additional internal medicine physician FTEs will be needed to maintain our current standard of high quality patient care for the new beds associated with the project.

12. Section C, Orderly Development, Item 3

The staffing pattern is noted. The applicant states that it matches that of existing bed units of equivalent bed count. As such, it appears that total estimated staffing of the Med/Surg service and the ICU services may total to approximately 571 FTEs and 294 FTEs, respectively, using the applicant's methodology. In terms of cost, both services appear to account for approximately 65% UTMC's total salary and wage cost reflected in the Historical Data Chart for 2013. Is the methodology used by the applicant consistent with these estimates? Please confirm.

The cost estimates used by the applicant for salary and wage amounts were extrapolated from current actual direct (patient care) and indirect (support services) expenses per patient day for similar nursing units. An existing med-surg unit, with patients of comparable acuities, was used for the new med-surg projection, and an existing critical care unit was used to model the costs for the new critical care unit.

The salaries and wages of only the nursing positions associated with this project, extrapolated to the entire hospital would not equate to 65% of total hospital salaries and wages. The salaries and wages on the Projected Data Chart include not only the clinical positions described in response to Question C, III, Orderly Development 3 of the application. The salaries and wages on the PDC also include allocations for salaries and wages for all ancillary clinical services (pharmacy, imaging, physical therapy, etc.), as well as non-clinical services (dietary, maintenance, administrative, etc.).

13. Section C., Orderly Development, Item 7.

The Joint Commission accreditation award effective September 2011 is noted. However, review of the award letter attached to the application and the TDH licensed facilities link on the HSDA toolkit, revealed that the accreditation will expire on September 24, 2014 before the application can be heard. Please explain the status of UTMC's accreditation at present.

UTMC was surveyed on September12, 2014, and is developing its corrective action plan. UTMC is confident it will attain renewal of its accreditation, which will be retroactive to September 24, 2014.

Review of the TDH licensed facility report also revealed the last survey by TDH was on August 20, 2008. If a more recent survey exists, please provide a copy of the survey (with plan of correction) and a copy of the acceptance letter by the Department of Health, as applicable.

The 2008 survey is the most recent by the Department of Health.

SUPPLEMENTAL- 1

September 29, 2014
11:46am

AFFIDAVIT

STATE OF TENNESSEE)
)
COUNTY OF KNOX)

I, Teresa Levey, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Teresa L Levey
Name

Sworn to and subscribed before me this the 26 day of September 2014, a Notary Public in and for Knox County, Tennessee.

Wendy S O'Neal
Notary Public

My Commission Expires: 3-31-18.

WENDY S. O'NEAL
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF KNOX

Original

ADDITIONAL INFORMATION

Supplemental -1

University of Tennessee Medical Center

CN1409-042

SUPPLEMENTAL #1
September 30, 2014
2:04 pm

STITES & HARBISON PLLC
ATTORNEYS

September 30, 2014

Jerry W. Taylor
(615) 782-2228
(615) 742-0703 FAX
jerry.taylor@stites.com

Mr. Jeff Grimm
Health Services and Development Agency Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

RE: University of Tennessee Medical Center
CN1409-042

Dear Jeff:

Please accept this additional information and clarification to the supplemental responses which were filed for this project on September 29, 2014.

The table on page 40 has been revised to reflect the correct current and proposed Year 1 total charges for the med-surg beds. This update was overlooked following a revision to the Projected Data Chart prior to filing the application. A Replacement Page 40 is submitted herewith.

The response to Question 6, B of the application has been revised to reflect a comparison of the applicant's proposed charges to some proposed charges recently approved for Skyline Medical Center, CN1406-020. This application had not been approved at the time the application was filed. A Replacement page 41 and an attachment are submitted herewith.

The response to Supplemental Question 20 has been expanded to confirm UTMC will provide a copy of any future correspondence regarding Joint Commission re-accreditation of UTMC. A Replacement Page 20 of the Supplemental Reponses is submitted herewith.

Please let me know if you have any additional questions or if additional information is required. We appreciate your assistance.

Sincerely yours,

STITES & HARBISON PLLC

Jerry W. Taylor

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

New Medical Surgical Beds:

Average Gross Charge per day:	$6,919.95
Average Deduction per day:	$5,104.85
Average Net Charge per day:	$1,815.10

New Critical Care Beds:

Average Gross Charge per day:	$8,733.10
Average Deduction per day:	$6,487.07
Average Net Charge per day:	$2,246.03

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Current and proposed charges for the relevant hospital services are reflected below. The charge increases represent normal increases over an approximate two year period, and are not a direct result of this proposal.

University of Tennessee Medical Center

Current vs. Projected Relevant Charge Data

	Current Avg. Total Charge/Day	1st Year Proposed Avg. Total Charge/Day	Current Room & Board Charge/Day	1st Year Proposed Room & Board Charge/Day
NICU Level 1 & 2	6,255	6,442	4,700	4,841
NICU Level 3	6,255	6,442	5,400	5,562
Critical Care	8,733	8,733	2,694	2,694
Acute Care (Inpatient)	6,920	6,920	1,045	1,045

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Comparable average charges of other providers for these specific service lines are not available to the applicant. And, since UTMC is the only academic medical center and Level I trauma center in the region, there really are no comparable hospitals in the area.

The Agency recently approved Skyline Medical Center for a relocation of med/surg and ICU beds (CN1406-020). A table comparing some selected proposed charges approved by the Agency for that project to the same DRG codes for this project are attached on the following page.

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

As reflected on the Projected Data Chart, both the med/surg and the ICU bed additions will have a positive net operating income in the first two years of operation. The margins decrease in the second year, resulting from assumed declining reimbursement rates from government payors. In any event, the Financial Statements reflect sufficient assets to ensure financial viability.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

As reflected on the Projected Data Chart, both the med/surg and the ICU bed additions will have a positive net operating income in the first two years of operation. The margins decrease in the second year, resulting from assumed declining reimbursement rates from government payors. In any event, the Financial Statements reflect sufficient assets to ensure financial viability.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

UTMC participates in both the Medicare and TennCare programs. UTMC contracts with all TennCare MCOs in the region. In addition, effective January 1, 2015 UTMC will be under contract with AmeriGroup Community Care.

For the whole hospital, the following was the Medicare and TennCare payor mix for the 12 months ending July 31, 2014:

UT Medical Center

Average Charge Data by MS-DRG
Jan - Jun 2014

	UT Average Gross Charge					Skyline Average Gross Charge			
	Current Average	Year 1	Year 2	UTMC Medicare with IME*		Current Average	Year 1	Year 2	Skyline Medicare
Med/Surg									
64 INTRACRANIAL HEMORRHAGE	42,221	42,221	43,066	12,739		599,199	599,199	599,199	10,509
65 INTRACRANIAL HEMORRHAGE	33,201	33,201	33,865	7,882		194,166	194,166	194,166	6,785
189 PULMONARY EDEMA & RESPIR	23,229	23,229	23,693	8,912		274,729	274,729	274,729	7,575
190 CHRONIC OBSTRUCTIVE PULM	22,721	22,721	23,175	8,564		249,883	249,883	249,883	7,308
193 SIMPLE PNEUMONIA & PLEUR	29,089	29,089	29,671	10,642		383,749	383,749	383,749	8,902
194 SIMPLE PNEUMONIA & PLEUR	20,171	20,171	20,574	7,147		251,477	251,477	251,477	6,222
392 ESOPHAGITIS, GASTROENT &	17,678	17,678	18,031	5,409		128,116	128,116	128,116	4,889
470 MAJOR JOINT REPLACEMENT	52,761	52,761	53,816	15,699		204,682	204,682	204,682	12,778
690 KIDNEY & URINARY TRACT I	15,140	15,140	15,443	5,627		163,586	163,586	163,586	5,056
871 SEPTICEMIA OR SEVERE SEP	32,526	32,526	33,176	13,551		598,422	598,422	598,422	11,132
ICU/CCU									
64 INTRACRANIAL HEMORRHAGE	56,340	56,340	57,466	12,739		571,045	571,045	571,045	10,509
65 INTRACRANIAL HEMORRHAGE	42,384	42,384	43,232	7,882		237,543	237,543	237,543	6,785
100 SEIZURES W MCC	43,044	43,044	43,905	11,107		400,258	400,258	400,258	9,258
208 RESPIRATORY SYSTEM DIAGN	57,433	57,433	58,581	16,729		327,785	327,785	327,785	13,568
247 PERC CARDIOVASC PROC W D	63,057	63,057	64,318	14,927		133,561	133,561	133,561	12,187
378 G.I. HEMORRHAGE W CC	36,756	36,756	37,491	7,336		88,979	88,979	88,979	6,366
638 DIABETES W CC	19,783	19,783	20,178	6,036		71,033	71,033	71,033	5,370
871 SEPTICEMIA OR SEVERE SEP	70,453	70,453	71,862	13,551		321,069	321,069	321,069	11,132
917 POISONING & TOXIC EFFECT	40,469	40,469	41,279	10,308		426,502	426,502	426,502	8,645
918 POISONING & TOXIC EFFECT	26,361	26,361	26,888	4,642		47,001	47,001	47,001	4,301

* Indirect Medical Education

Source: Internal Hospital records & CN1406-020

UTMC was surveyed on September12, 2014. The Joint Commission made no conditional level findings. UTMC is developing its corrective action plan, which will be submitted to the Joint Commission shortly. UTMC is confident it will attain renewal of its accreditation, which will be retroactive to September 24, 2014. When UTMC receives additional information form the Joint Commission, this will be submitted to the HSDA.

Review of the TDH licensed facility report also revealed the last survey by TDH was on August 20, 2008. If a more recent survey exists, please provide a copy of the survey (with plan of correction) and a copy of the acceptance letter by the Department of Health, as applicable.

The 2008 survey is the most recent by the Department of Health.